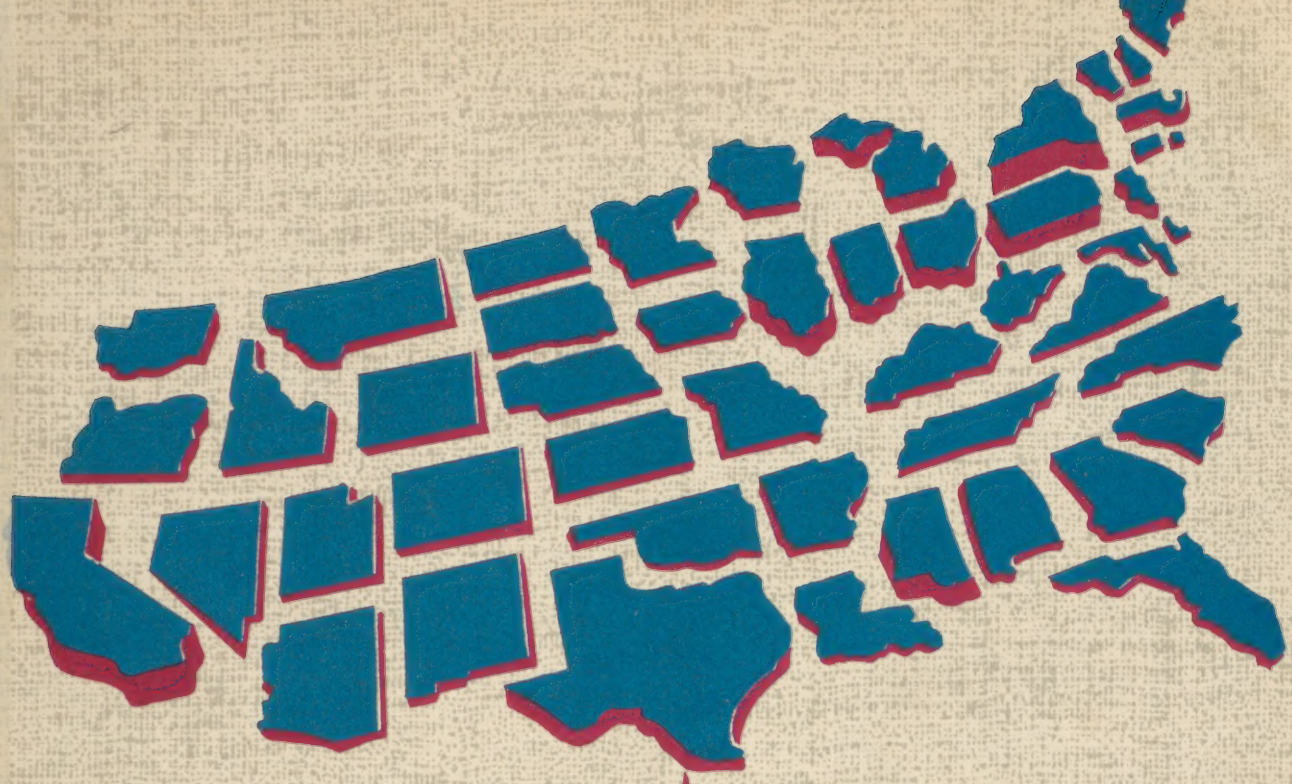


A Budget Survey

OF STATE MENTAL HOSPITALS

Conducted by

THE ILLINOIS DEPARTMENT OF FINANCE

1948

This Survey was conducted by the Illinois Budget Division under the supervision of T. R. Leth, Budget Director.

Address communications about the Survey to T. R. Leth, Illinois State Department of Finance, Springfield, Illinois

STATE OF ILLINOIS . . . DWIGHT H. GREEN . . . GOVERNOR

A Budget Survey
OF STATE MENTAL HOSPITALS

presenting

the replies from the forty-eight states on the questionnaire "Commodity Costs and Budgeting for State Mental Hospitals"

DEPARTMENT OF FINANCE
M. A. SAUNDERS . . . . . *Director*
T. R. LETH . . . *Assistant to the Director*

Foreword

Our times are characterized by the heavy, and insistent demands upon government for increased and improved public welfare services. State governments are faced with demands not only for increased facilities to care for more individuals but also for higher standards of care. Nowhere is this more apparent than with the state mental hospitals. To feed, clothe, house, and at the same time try to rehabilitate the ever-increasing number of mental patients is a major undertaking. The effective discharge of this important social responsibility is utterly dependent on sound fiscal planning. Everybody agrees that the state should do whatever is necessary to secure healthful living conditions, a healthful diet, and competent care for the mentally ill and mentally handicapped. There is not the same unanimity on how all this can be provided. It is deceptively easy to say that all that is needed is more money. The practical question is how much money is needed and can that amount be made available. In essence then, we face a large and difficult budget problem. While there are never any easy budget problems, budgeting for mental hospitals presents particular difficulty, especially in these times of mounting costs. If we could know what price levels are to be encountered during our next fiscal period, fiscal planning would be simplified. But, even if such foreknowledge were possible, it would be necessary to have the detailed and precise facts on current operations to use it effectively. Also, we find that we need precise facts in order to determine whether faulty fiscal planning or some entirely different factor is responsible when standards of care at our institutions are inadequate or inadequately maintained. It is from the knowledge of existing conditions that we can hope to effectively plan new and additional facilities as well as to improve present operations.

Believing that we might benefit from the experience of other states with similar problems, Illinois questioned the other forty-seven states on their cost estimates and their methods of planning budgets for mental hospital operations. We believed that an interchange of ideas on these problems would be mutually beneficial. This view received unanimous support, as witnessed by the fact that every state took the trouble to give careful and detailed reply to our comprehensive questionnaire. The questionnaire replies from all forty-eight states are embodied in this report. We all have known that the conditions and circumstances encountered in budgeting for mental hospitals are far from being identical from state to state. These variations are clearly revealed in the results of this survey. However, the basic similarities between the states on many aspects of the problem are definitely noticeable. At the same time, the merits and demerits of the various methods for handling this or that part of the problem become quite apparent. From the whole, there emerges a sort of frame of reference that should prove useful to each state in evaluating its problem and its success in dealing with the problem. A single study of this sort cannot hope to provide any definite solution to the problem of budgeting for state mental hospitals. We do believe that this pooling of knowledge will suggest many ideas for improving budget planning, not only for mental hospitals but also for other types of state operated institutions, notably the correctional group. Finally, we hope that this presentation will promote further exchange of information and ideas between the states to the end that additional investigation and analysis will develop improved methods for fiscal planning and administration.

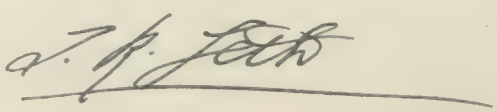
M. A. SAUNDERS

August, 1948

ACKNOWLEDGMENTS

A time-honored principle of government is that the internal affairs of a sovereign state are its own exclusive concern. Grateful tribute is hereby made to the splendid spirit of cooperation among the forty-eight states, all of which have freely offered detailed and intimate information on the administration of their mental hospital programs. The state officials who made this study possible are listed in the section "Contributors to the Survey." To each of these individuals we extend our deep appreciation for the trouble they took to answer our inquiries and for the privilege of reproducing the information gathered.

It is a pleasure to acknowledge the valuable contributions of the Federal Bureau of the Budget, Iowa State College, the University of Illinois, the Illinois Department of Public Health, and the Illinois Department of Public Welfare. The Budget Bureau offered helpful suggestions and gave permission to reproduce certain Federal forms. The two universities, through their Home Economics departments, furnished us an analysis of the diet information assembled in the survey. Further evaluations of diets and rations were provided by the nutritionists of our State Departments of Public Health and Public Welfare.



Contents

THE SIZE OF THE JOB FOR STATE GOVERNMENTS

There are 539,000 patients in the State Mental Hospitals of the country

THIS MEANS **1 OUT OF 263**

—one person out of every two hundred-sixty three is in a state mental hospital.

THIS IS

—enough people to populate an entire city as large as NEW ORLEANS.

THIS IS

—as much as the proposed strength of our NAVY and MARINE CORPS personnel.

THE PROBLEM OF MENTAL HOSPITAL BUDGETS AND A PROGRAM FOR BUDGETING

THE care of the mentally ill and mentally deficient has been left almost entirely to state government. Day in and day out, there are some 539,000 patients in state mental hospitals. At an average cost of $1.44 per day, this means that the states are spending 283 millions each year on hospital care for mental patients. This large sum is required just to operate present hospital facilities. It does not take into account the millions needed for new hospital construction, nor does it include the cost of out-patient clinics and other activities of the general preventive program for mental health. Authorities on mental health maintain that many more patients need hospitalization than can now be accommodated. They also warn that mental and nervous disorders are becoming increasingly common. A higher prevalence of illness coupled with a greater general population will make future demands on the states even heavier than the current burden. As it is, we are having trouble in taking care of our present responsibilities. Those difficulties are demonstrated by the many problems encountered in making and administering budgets for operating our hospital programs.

The problem in Illinois is rather typical of the problem in other states. Illinois has difficulty in anticipating the future cost of operating its mental hospitals. So do the other forty-seven states. Illinois finds great variations in the costs among its various mental hospitals. So do all the states with more than one hospital. Illinois lacks a clear-cut, effective scheme to obtain a full analysis of its hospital operating costs. So do almost all the states. These are some of the salient facts revealed in this survey of budget practices and budget problems covering the forty-eight states.

The survey was made by a mail questionnaire addressed to the official in charge of the state budget. In the majority of instances the budget officer supervised the formulation of his state's reply. In some cases the questionnaire was referred to the operating head of the mental hospital system. One section of this report (pages 63-67) lists the state agency responsible for the mental hospital program and goes on to give the names and titles of the officials who contributed information. The fact that every state took pains to reply in detail on so many difficult questions demonstrates the universal interest and concern over the mental hospital problem. Valuable information on many of the special budget problems can be found in the data and detailed comments that appear in the latter part of this report.* These indications of what the states think and what they are doing should stimulate, as well as help, the questioner to find his answer.

PER CAPITA COSTS AND THEIR APPLICATION

In any fiscal planning, the natural way to consider a cost problem is in terms of unit cost. For mental hospitals the basic unit is the patient. To compare one institution's cost with another, per patient costs provide the simplest and easiest means of accurate comparisons on operation. In estimating the total costs of future operation it is easiest to calculate per patient needs and apply this to an estimate of the future number of patients. What, then, is a reasonable per capita cost for maintaining a patient at a state mental institution? Should it be 50¢ a day, $5.00 a day, or the national average† of $1.44 a day? This is the basic question to be answered by the mental hospital budget.

*The section "FINDINGS" (page 15 ff.) contains a discussion summarizing the actual data assembled. This discussion is followed by tables presenting each state's reply to the questions and the particularized comments made in explanation of those replies.

† Based on data received from 46 states. See Tables.

Even a casual inspection of the reported per capita costs demonstrates the absence of any particular figure that can be taken as a standard cost for the mental hospitals of the country. While one state with three hospitals has been able to confine the costs within a spread of seven cents, we find no comparable situation in any of the other forty-seven states. At the other extreme is a state with 26 hospitals where the spread between the lowest and highest per capita cost is $15.13 per day. Generally, the cost variation among hospitals of a particular state is even greater than among the forty-eight states themselves.

When attention is confined to hospitals with over 4,000 patients there is more consistency in per capita costs than for any other particular grouping of the hospitals. The spread between low cost and high cost in the group is only one dollar per patient and quite naturally the average for the group is very near the national average for all hospitals. Some of the hospitals of moderate size have the lowest per capita costs, but in the group itself, costs are evenly distributed along the entire scale from low to the very high. The highest costs are found in a group of twelve small specialized hospitals each with less than 500 patients. All in all, there is no satisfactory way to explain cost variation on the basis of hospital size, even when restricting attention to the hospitals of a single state.

The skeptic may choose to believe that large cost differences between hospitals within the state merely show up poor administration. However, one need not look far to see that between hospitals there are intrinsic differences which cannot be attributed to administrative inefficiency. Obviously, some types of patients require more costly care than others. Just as obviously, no two hospitals are likely to have the same proportion of their patient population suffering from the same illness. In a large hospital system it is prudent to limit the costlier types of care to as few hospital facilities as possible so as to conserve specialized equipment and personnel. It is evident that a hospital giving extensive medical and other remedial treatment to its patients will be far costlier than one where the patients receive little more than custodial care.

While type of care accounts for the largest cost differentials between hospitals, there are other important contributing factors. An obvious one is the relative efficiency of physical plant. Plant efficiency at many institutions is impaired not just by obsolescence, but by the added hazard of overcrowding. Then, too, just like the ordinary household, every institution has its own housekeeping problem. The institution that produces an important part of its food requirements presents quite a different cost picture from one that can produce little of what it uses. Other factors, such as distance from major markets and major producing areas, contribute to price differentials that greatly affect costs. Since there are these intrinsic and natural differences among hospitals, no particular virtue can attach to an institution or group of institutions just because the per capita cost figure is at the national average. The average merely furnishes a convenient bench mark. Each state must judge its hospital costs in terms of

a) the standards of patient care that are required by its mental hospital program, and
b) the efficiency with which its institutions are operated.

Even though it is natural that per capita costs vary considerably from hospital to hospital, might we not expect a close agreement among state-wide average costs? After all, the state-wide problem of mental care should be quite comparable from state to state. However, the survey shows that the state-wide averages now run from a low of 70¢ per day to a high of $1.90, while the national average is at $1.44. These variations cannot be explained away by the assertion that the states have calculated their costs in different ways. The survey reveals rather close agreement both as to method of calculation and as to the kind of items included in the operational cost of maintaining mental patients. Almost every state counts in all items of recurring expense and excludes non-recurring expenses, such as permanent improvements. Also, the states generally agree on using an average daily population as the measure of patient load.

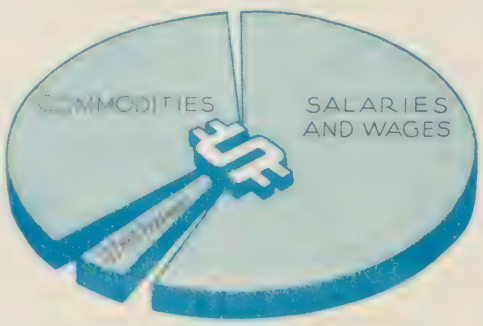
Since some states receive reimbursement for certain of its mental patients and others do not, reimbursement practices could introduce discrepancies in the cost calculations from state to state. While paying patients in some states receive certain additional comforts, there is no evidence that this materially affects the average per capita cost of maintenance.

If the cost of care for paying patients were excluded from the total cost reported, there would be a decided distortion of the cost picture. Fortunately for the study, this is not the case because most states have reported the cost for all patients. Generally, the states simply consider reimbursements as general income. The states where the hospitals must depend on this income for part of their actual operating funds complain of the budget difficulties introduced by having to estimate future proceeds from paying patients.

The state-to-state variation in per capita costs is more than can be ascribed to differences in geography, wealth, and other attributes of the state. While it is true that the highest costs are found in the North and Far West regions of the country, there is no regional pattern of cost for any of the nine regions of the country. Actually, the real differences in cost from state to state depend on the extent of each state's program for mental patients and the standards employed in operating the program.

Surveying the entire situation makes it clear that every institution needs an individual budget constructed upon a full understanding of its specialized circumstances. Those specialized circumstances and individual needs are readily described in terms of specific unit costs. Unit costs make it easy to calculate the aggregate expense to be covered in the budget. Similarly, a continual evaluation of the fiscal position in terms of unit costs provides an effective tool for administering the budget.

The Budget Dollar



ILLINOIS' BUDGET FOR OPERATION OF THIRTEEN MENTAL HOSPITALS BIENNIUM 1947-1949

THE PROBLEM OF PERSONAL SERVICES

The largest part of the mental hospital budget goes for personal services.* It is hardly surprising that the greatest cost variations among hospitals throughout the country occur in personal services. Standards for staffing, as well as salary scales, vary from state to state. A full study of this problem would entail gathering a large mass of data on job classifications and salaries, not only on hospital employment, but also on employment in other state services. The discussion here is limited to considering a few basic principles connected with budgeting salaries and wages.

Budgeting for the personal services required to operate mental hospitals is somewhat like budgeting fixed charges. Once the salary rates and the number of persons to be employed have been specifically decided upon, the amount that will be expended is a foregone conclusion as long as full staff is maintained. However, staff is seldom kept at full strength. Besides, the exigencies of operation often make it necessary to substitute one kind of employee for another and to adjust in many other ways. In recent times staffing has been extremely difficult, both because of the general manpower shortage in all occupations and because government employment has been less attractive than other means of earning a livelihood. As a result, expenditures for personal services have often been less than the budgeted or appropriated amounts. These and many other situations arise that cannot be anticipated in the budget. Good fiscal administration requires an understanding of the extent and effect of all such situations before the end of the fiscal period.

The Federal Bureau of the Budget has developed a method for evaluating the personal service situation in Veterans Administration Hospitals that could be very useful to a state fiscal administrator. These Federal reporting forms are reproduced in Appendix A, pages 70-77. The Federal "Statement of On-Duty Hospital Personnel" is "designed to show the personnel employed in the operation and maintenance of each facility and the ratios

*Personal service costs and employee distribution for most of the states have been reported in the publication "State, County and City Mental Hospitals: 1946" released by the Bureau of the Census, Sept. 10, 1947.

of the different classes of employees to the average daily load."* The statistical report is constructed so that the inherent differences between institutions are readily distinguished. At the same time the form shows whether or not the various institutions are staffed up to standard (patient-load-per-employee). Of course, Veterans Administration facilities cover many more types of hospitals than are to be found in a state mental hospital program. Nevertheless, in a state with several mental hospitals it should be recognized that requirements at every institution are far from identical. For example, the institution that takes care of only mental patients who are otherwise healthy will differ in its personnel needs from one that has a number of mental patients with a concurrent illness, such as tuberculosis. Moreover, an institution which engages in the rehabilitation of mental patients requires certain types of personnel not used in a hospital devoted just to custodial care of nonremediable patients. A state can therefore make excellent use of an analysis of personnel utilization along the lines of the scheme used for VA hospitals.

The statistical reporting forms used by the Federal Bureau of the Budget require much detailed record-keeping before they can be filled out. The state hospital record-systems may not embrace all that detail and many states may not find it feasible to keep records elaborate enough for the Federal forms. In state mental hospitals, the largest segment of personal service expenditure is confined to three broad classes of personnel, namely, physicians, nurses, and attendants. With this in mind, a simplified form has been drawn up and presented in Appendix A, page 78. This form offers a means for comparing actual operations against the anticipations of the budget, both as to number of personnel and the actual expenditures for personal services. The unit for measuring the amount of personnel (man-hours, man-days, etc) is a matter of individual preference. A report like this makes it relatively easy to interpret the significance of the usual accounting statement.

Keeping informed on the basic elements of operations, as reflected in a report of the sort described, is part and parcel of the job of administering the budget. The conscientious fiscal administrator wants to know whether the standards established in the budget plan are actually maintained. The prudent budget officer wants to have the same kind of basic facts before him when passing upon a new budget. Some basis is needed for estimating the cost of operating such new or additional facilities as may be requested. With every new budget it is almost inevitable that there will also be proposals for general pay increases and staff enlargements. By their very nature, budget justifications cite only facts that support the requests. Therefore, it is essential to have independent factual information at hand, if the budget officer is to make intelligent decisions on the problems that confront him.

*Bureau of the Budget, Executive Office of the President: "Instructions for Preparation of Statistical Reporting Forms for Federal Hospitals. April 1948."

COMMODITIES

The particular problem that gave rise to this survey was budgeting for commodities. By commodities we mean all the food, fuel, clothing, household needs, plant maintenance supplies, and the thousands of other items that are consumed in caring for the mental patient and operating the mental hospital. While the total cost of commodities for the institutions is not as great as for personal services, the charges for commodities form the next largest class of expenditure and contribute the greatest difficulties in budgeting. To make a biennial budget for commodities means, in effect, that one simultaneously estimates the quantities to be used and the prices to be paid throughout a two-year period, long before that two-year period begins. On the face of it, there seems little to do except make a blind guess. Actually, this is pretty much what is done. However, there is growing realization that blind guesses tend only to compound the inherent troubles of keeping the institutions properly supplied. Controllers of fiscal policy are now requiring more precision in the formulation of budget plans. They insist first that all guesswork be reduced to the smallest possible area, and second, that the guesses be informed forecasts rather than blind inspirations. This serves to make the budget a realistic plan for future operations. Nobody can

predict exactly what price levels may prevail during the next fiscal period. At best, all that can be safely predicted are upper and lower limits to a general movement of prices. Also, wise planning does not count on just one eventuality. So it becomes advisable to construct a budget plan that will enable the operating agency to successfully meet several different sets of conditions, any one of which may logically arise during the period for which plans are being made.

How can the guesswork in budgeting for commodities be reduced to a minimum? Most of the guesswork is replaced by knowledge when the facts on how commodities are being used and how much they cost are fully available at all times. For this there must be a comprehensive system of watching commodity consumption. The system ought to be based on a common sense classification of the commodities in use. The ordinary state accounting procedures fail to produce quite the kind of information that is needed. The standard state accounting practice is designed to fit an auditing system whereby the state can be assured that funds are expended for the objects intended and in the manner specified by law. This general accounting system is quite cumbersome as it is, and, very likely, it would be completely unworkable if it were also to encompass cost accounting. A separate cost accounting system, or some workable approximation thereto, is essential if the mental hospitals are to have the facts on commodity consumption.

The survey shows that many states have little factual information on their commodity consumption. This is clear from the many omissions to specific survey questions on commodities and their costs. On the other side, there are several states that have particularly well-conceived and well-developed systems for ascertaining their commodity costs in full detail. Those states that have the facts on their commodity operations exhibit the best command over their institutional budget problems. This is particularly well illustrated by the manner in which the states handled the knottiest commodity problem of them all, namely, food. Food, of course, accounts for the largest part of commodity expense. Any system that can cope with the complexities of the food problem will also suffice for almost all other commodity problems.

FOOD — THE MAJOR COMMODITY PROBLEM

A system that furnishes consumption and cost information on food should be designed to meet the many complexities without being submerged in a vast amount of detail. Food procurement is quite complex under present operating practices. Generally, there are three distinct sources for procurement, namely,

a) outright purchases,
b) surplus commodities, and
c) home production.

The out-of-pocket expenditures for food vary according to how much or how little can be procured from surplus commodities and home production.

SURPLUS COMMODITIES — Surplus commodities are supplied without cost to the state by the Federal government from its excess stocks of certain agricultural products bought to support farm prices. State institutions receive such essentials as eggs, potatoes, and the like from this Federal surplus. The surplus commodities are very often looked upon as a windfall, above and beyond the normal supplies. Under such circumstances, there is a natural tendency for part of these unlooked-for supplies to be wasted. The possible waste has little implication in the problem of budgeting. However, there are two important ways in which gifts of food distort the supply situation and thereby affect budget requirements. First, the windfall may be used to raise the diet standards to a point unanticipated when budget requirements were set up. This has the effect of making a continuing commitment to a costlier scale of operations without advance assent by those who must guard the purse-strings. Second, the receipt of the surplus gifts may conceal the fact that funds are insufficient to provide the full amount of food necessary. In this case, when the quantity of the gifts contracts, the administration may face an emergency which it is not prepared to meet. Either way, there is created a problem in preparing and administering the budget.

Elementary prudence dictates that budget planning cannot be based on an assumption as to how much can be expected from surplus

commodities. The budget should assume that the state will pay for everything that is needed. Therefore, it is incumbent upon the institutions to consider the value of the surplus commodities consumed as a charge against their allotments for food. This requires placing the market value on the gifts and counting them into operating costs. Only then is it possible to keep the true cost picture from being distorted by the many uncertainties that can be introduced by the windfalls from surplus commodities.

HOME PRODUCTION — The majority of institutions produce important amounts of food on their own farms and gardens. The kinds and amounts so produced vary greatly from institution to institution. For example, one institution may produce all of its own milk, while others produce little or none. In any event, the out-of-pocket expense for purchased milk, as opposed to home-produced, is quite different in character. The same is true for almost any other food that is home-produced. Farming conditions also vary widely from one institution to another. This whole situation contributes in a very important way to the differences in costs from institution to institution as already noted. The home production factor complicates the problem of gauging needs, even when only one institution is involved. Unless some device is used to isolate the operation of producing units from the ordinary institutional operations, the problems of management and budget planning tend to become too complicated.

It is for this reason that institutional farm operation is more and more being considered as a distinct enterprise instead of an integral part of the institutional operations. Under this system, the farming operation has its own budget and may even have a separate appropriation. The institution is charged for the products it uses at the going market prices and funds are transferred from the institution account to either a revolving fund for farm operations or back to the general revenue fund of the state. A system of this sort also helps to put a premium on efficient farm operations.

There are some objections raised to the practice of putting farm operations on a business basis. One of the important considerations in having institutional farms is the therapeutic value of the work opportunities afforded the patients in farm work. While the use of patient labor makes the calculation of labor costs somewhat of a problem, that feature is relatively unimportant in comparison with the other administrative advantages in conducting the farm like a business. The same principles apply to some of the large scale processing operations, such as butchering and food canning.

FOOD PURCHASING — Even though surplus commodities and home production supply important amounts of the food requirements, the primary problem with food is outright purchases. Most of the states have a central supervision over all institutional purchases. The majority of these states place the responsibility in the hands of a state purchasing agent. An effective state or institutional purchasing system utilizes a set of standard specifications for buying commodities. In addition, the purchasing department very often tests for quality and correct measurements of the commodities that are bought. This is motivated by the philosophy that the state should "get a dollar's worth for every dollar spent."

Standards are particularly important for food because of the variety of ways it is sold, the great variations in its quality, and its generally perishable nature. However, there are other very good reasons for applying standards to purchases. A very important consideration is the need of simplifying record-keeping on the handling and ultimate distribution of commodities to the point of consumption. Inventory and consumption records tend to be unmanageable when the same commodities turn up in a great variety of package sizes. Furthermore, the mass processing methods employed in the institutions require uniformity of material for efficiency. For best operating procedure, the food obtained from surplus commodities and home production should be graded and priced according to the standards used on purchased food.

While central purchasing of every item needed at the institutions looks logical, there are important practical considerations that make it also necessary for each institution itself to make some direct purchases. Perishable items which cannot be bought under contract arrangements are often bought directly by the institution. The same applies to emergency needs and miscellaneous small incidentals. Under a well-conducted central purchasing system, the direct purchases are

made pursuant to an authorization issued by the central purchasing agent and a report is made to him of the quantity bought and price it carried. Such back-reporting is essential if the purchasing agent is to exercise policy control over all purchasing and keep informed on pricing. A central purchasing agent who keeps fully informed on prices can be of inestimable help to the budget authorities.

STORE REPORTS

The stores system for supplies furnishes the real point of control over the commodity problem. In well-conducted institutional operations, all supplies pass through the stores and records are made there to show the course of day-to-day operations. Efficient storekeeping collects the essential facts on commodities needed for planning both the operations and the budget. The record-keeping system of the stores should embrace all of the following functions:

1) Check the receipt of goods so as to authorize payment of invoices;
2) Record all receipts in terms of quantity and value for each of the procurement sources: purchases, surplus commodities and home production;
3) Maintain a perpetual inventory of the supplies on hand by recording the quantities and value of all goods;
4) Maintain records of issues to each of the points of consumption within the institution, together with summary records showing distribution by major operational functions; and
5) Make regular reports summarizing a) receipts according to their classification, b) inventory position, and c) consumption according to its distribution.

Even the most judicious system of store reports will contain more detail than is directly useful in analyzing the institutional operations. It is, therefore, incumbent upon the institutional management to condense the detail into easily interpreted summaries of consumption and inventory position. The need for carefully summarizing the stores experience is particularly necessary in the case of food with all its complexities of procurement and consumption.

DIET STANDARDS

The evaluation of food consumption must make use of record-keeping beyond what is carried on through storekeeping. The institutions, almost without exception, keep records of the number of meals served. Coordinating the number of meals with the store report of issues over a period makes it possible to calculate meal costs. Also, meal records are very important for calculating the extent to which diet standards are maintained. The importance of diet standards in large scale feeding cannot be overemphasized. However, the survey failed to get much information on the subject. (Such information as was gathered has been summarized and evaluated by recognized authorities on diet problems and is presented in Appendix B.) If failure to submit a diet schedule is any indication, there are many states that have overlooked the value of diet standards.

Properly designed diet schedules are an indispensable tool in the administration of the hospital or hospital system and a primary aid in efficient budgeting. The way in which Rhode Island employs diet standards is a particularly good example of their usefulness. California, New York, New Jersey, and Pennsylvania also make excellent use of diet standards in both budgeting and operations. A proper diet plan takes into account the differing needs of the persons fed by classifying them according to age, kind of activity or work performed, etc. The great importance of employee maintenance is recognized by having specific standards for employee meals as well as for the various kinds of patients. The need to have diet standards for operating institutions is as obvious as the fact that a bottle-fed baby needs its milk compounded by a formula.

The importance of diet standards for budgeting is somewhat less obvious, but equally real. First of all, the budget is an instrument for executing policy. As such, the budget must make adequate provision for fulfilling whatever policy may have been adopted for the fundamental job of providing food for institutions. The diet standard furnishes the yard-

stick by which an effective budget plan can be laid out and the means of measuring the actual working of the plan. However, the mere possession of a diet standard does not guarantee the realization of the advantages just referred to. A number of states report that one of the important factors in their recently increased commodity expenditure has been diet improvement. Only a very few appear to know exactly how much of their increase was due to that improvement. Still fewer states were able to report that their budget had anticipated a costlier diet standard. Unless the agency knows its costs, there is no way of anticipating the effect of improving standards. A large deficit in the commodity appropriation is easily precipitated by a decision to improve diet standards when no consideration or advance planning is given to the costs involved. Such decisions must be made a part of the budget plan.

NEED FOR COMMODITY RECORDS

All the complexities of the food problem can be reduced to manageable form when the operating agency avails itself of a system for knowing and measuring food consumption which will embrace all of the factors just discussed. The budget authority's direct concern is only that the operating agency has such a system, that it is functioning, and that budget requests can be backed up by precise facts available from the system. For budget purposes the following information should be available on food:

1) The per capita cost of food consumption for each major type of patient and for the employee group;
2) The total value of supplies procured from each of the primary sources—outright purchases, surplus commodities, and home production;
3) The quantity and value of inventory for certain broad classes of goods (each class should also be evaluated as to how many day's supply is on hand); and
4) The quantity and value consumed from certain selected commodities which have great influence on the cost structure

This sort of information provides a sound basis for constructing a budget and is invaluable in interpreting budget requests. At the same time there is provided an effective means of administering the current budget with a full understanding of the fiscal position at all times. The per capita cost, as already brought out, can be simply extended to provide a reliable figure on total cost with assurance that there are no important unforeseen elements. The data on how much of the supplies originate from the three independent sources provide the means of knowing actual out-of-pocket expense. The report on inventory position provides the means for eliminating gross errors in the computation of consumption. Recording the inventory position along with data on operations can prevent the danger of overdepletion of inventory and also prevent accumulation of inventory from being confused with the recurrent expense of commodity consumption. The information on consumption of selected commodities important to the cost structure furnishes basic data needed on prices and their effect.

Procurement, consumption, and inventory information is just as necessary on other commodities as on food. All regularly purchased commodities require cost controls similar to those discussed. The requirements for commodities used sporadically need only to be considered as an aggregate. In general, commodities other than food do not require as elaborate records because both procurement and consumption are much simpler. For them, procurement is almost entirely confined to outright purchases. Information on commodities other than food may be streamlined so as to reflect only the aggregate per patient cost for the major operating functions at each institution.

States with several institutions at times have had the commodity situation confused by indiscriminate transfers from one institution to another. Efficient procurement, inventory, and consumption record-keeping can readily take care of the necessary transfers without having them distort the true picture of costs and operations. Of course, good budget planning and efficient operation tend to make transfers between institutions unnecessary.

Well-kept records of commodity consumption will reflect the characteristics of the institution and its operation. Analysis of the data makes it possible to give practical interpretation to the differences that exist among

the institutions within a state mental hospital system. Those data provide the starting point for constructing the budget of each institution, and provide criteria for judging its adequacy.

PRICES

The current inflation of prices makes all our budget problems more acute and at the same time tends to divert attention from important, but seemingly unrelated, problems. This overshadowing also encourages the wishful thought that if we can just get by the current price crisis, everything will be easy. Actually, sound management can never afford to become complacent about prices. For this reason, measures for dealing with the price problem should not just be geared to crisis. The discussion here is intended to reflect the principles that will be useful and needed under any circumstances.

The survey asked the states for the average prices paid over the three months of July to September, 1947 for certain food items. The replies clearly demonstrate the complexity of the price problem and the great concern over prices. The prices reported vary according to geographic area, but not just in the way one might expect. For instance, lower prices ought to prevail in areas that are closer to major marketing and producing centers. Apparently Minnesota is paying twenty-two per cent more for flour than New Hampshire and California is paying thirty per cent more for dried peaches than Vermont. Actually, these peculiarities reflect differences in buying arrangements. The practice of buying under a quarterly or even yearly contract at a fixed price tends to make state purchase prices lag far behind the market at times. The comments of the states on prices clearly indicate that each institution as well as each state has its own price structure, not quite duplicated elsewhere.

It is apparent that the movements of the standard price indexes, such as the Bureau of Labor Statistics indexes of wholesale prices and retail prices, do not fully reflect the changing price situation that is encountered by the institutions. While the Bureau of Labor Statistics indexes are very useful for interpreting the general situation, they represent quite a different pattern of buying than what the institutions encounter. The movement of institutional purchase prices tends to lag behind the market. Institution prices also include variable transportation costs that are not reflected in market prices. Even more significantly, the institutions do not buy commodities in the same proportions as presumed by the weighting factors used to compute the official price indexes. Actually, no two institutions even in the same state are quite certain of having their purchases distributed among the commodities in the same way.

There is a real need for getting a measure of the average level of food prices, if we are to avoid being entrapped in the confusing variety of price situations encountered in supplying even a single institution. A simple way of measuring the situation is provided by an institutional price index. An index summarizes the net effect of all the prices used in its computation. Careful study of the cost and price structure for an institution will reveal a group of items whose prices and consumption largely determine the total costs. Such a study will also reveal the relative importance of those items. The calculation of a price index is then a matter of simple arithmetic and can easily be carried on by a good clerk. Possessing a price index that is calculated at regular intervals, management can readily note and interpret the possible effects of changing conditions. That kind of awareness makes it possible to modify plans and policies before matters get out of hand. The ability to use the information to its best advantage further depends on maintaining a full interchange of information between the purchasing agent, the institution management, and those who plan the diet. Too often, these three work almost independently of each other and lose the advantage of coordinating their activities.

CONSTRUCTING THE BUDGET

The construction of a budget can be relatively simple when adequate per capita cost data on present operations and a price index are available. The per capita cost information has to be specific for each of the major aspects of operations:

1) Personal service costs at a specified level of staff,
2) Commodity costs at a specified level

of prices defined in terms of the institutional price indexes , and

3) All other expenses that vary appreciably with patient load.

With this, a tentative budget can be drawn up at any time from the actual experience. In other words, the actual experience can be applied to a hypothetical patient load and price level. Such a tentative budget can take care of most of the mechanical details in the construction of the final budget. With the mechanical details taken care of well in advance, the final budget can be made quickly after decisions have been made as to

a) the level of operating standards to be maintained,
b) the estimate of population, and
c) the level of prices to be covered.

This method reduces decisions on a final budget to the basic elements of policy determination.

The decision on price level is not necessarily a gamble on what future prices will actually be. To illustrate, suppose that the level of prices in the base period corresponds to a level of 121 for the institutional price index. In view of the latest information on price trends suppose it appears reasonable to assume prices will average from 5 to 15 per cent higher than in the base period. So, we decide that reasonable provision for the future can be made by a budget based on a price index level of 136. Such a decision does not pretend that prices will behave just that way. It only specifies a reasonable provision. If there is great uncertainty about the future course of prices, additional provision can be made by setting up a contingency fund to be used when prices have risen too far beyond the anticipated levels. The price index then gives an objective justification for authorizing the use of the contingency fund.

A method of this kind can go far to bring fiscal supervision out of an aura of conflicting conjectures into a realm of considered decision based on solid facts. Furthermore, the very existence of such a method of fiscal supervision makes for restraint and prudence on the part of those engaged in the actual operations. This salutary effect is based on the same principle as governs the use of a lifeguard at a bathing beach. The lifeguard seldom finds it necessary to more than call the bather's attention to the imminence of danger if a certain course is too far pursued. The very presence of a guard is a reminder to be careful.

GENERAL PRINCIPLES FOR BUDGETING

The information on state hospital budgeting which has come from the forty-eight states should suggest to any state a number of ways to improve its budgeting. Beyond that, the survey re-emphasizes the basic principle that budget problems go hand in hand with operating problems. To be successful, the budget must be based on a full recognition of the circumstances and conditions facing the operating agency. Such recognition is not only possible, but practicable, when the operating agency specifies its needs in terms of well-defined standards and bases its budget request on a specific plan of operation built upon a precise knowledge of the facts and circumstances governing operations. For this, the operating agency needs the following administrative aids:

1) Operating standards for
   a) the personal care of patients, i.e. personnel quotas, and
   b) the diet of each important class of persons fed, employees as well as patients;
2) Continuous analysis of the operating costs so that all major classes of recurrent expense are expressed on a per capita cost basis; and
3) A records system on commodities that at all times reflects the situation with respect to procurement, consumption, and prices.

The operating agency which avails itself of these aids will have the essentials for

1) Efficient and economical operation,
2) Effective administration of the current budget, and
3) Construction of the next budget.

Budgeting is a continuous process, next year's budget gradually developing out of the administration of this year's budget. In an efficient organization, the budget is a fiscal plan shaped to a plan of operations. In this connection, it is important to recognize that a

budget is not a substitute for a plan of operations. If operations are haphazard, there is little possibility of getting a realistic budget in the first place. Furthermore, it is a foregone conclusion that even the best planned budget will fail unless its administration is rooted in well-conceived operational plans.

When operation is well-planned, it is directed toward specific goals. There is also a timetable for the goals being sought. This last is particularly important, because the budget must be geared to operations so that fiscal resources become available when, and if, needed. It is unrealistic to make budget provision for expenditures on a scale that has no chance of being attained during the fiscal period to be covered. For example, a hospital, or hospital system, might have as its ultimate goal a particular ratio of physicians to patients, but knows that so many physicians cannot possibly be secured during the initial fiscal period. A timetable adjusted to the realities of the situation will schedule a series of successive goals until the ultimate is attained. Several states are doing just that in the current period of personnel shortages.

There are some who take the position that any detailed concern over the mental hospital budgets is entirely unwarranted and unnecessary. These individuals argue that the state is going to have to take care of all the mental patients anyway, and will have to spend whatever that may cost. Therefore, they say, the legislature should appropriate whatever is requested without any further ado. While this view is in many respects quite plausible, there are several irreconcilable inconsistencies in such a policy. Almost anyone will grant that everything possible should be done for the unfortunates who are wards of the state. At the same time, the legislature and the state administration are mindful of their responsibility to provide enough to take care of the situation. But what guarantee is there that an appropriation is adequate unless there is a solid factual basis behind the request for funds? Also, is there a single state administration that has not pledged itself to economy and efficiency in government? How can economy and efficiency be secured in the absence of a realistic plan for utilizing the funds of the state?

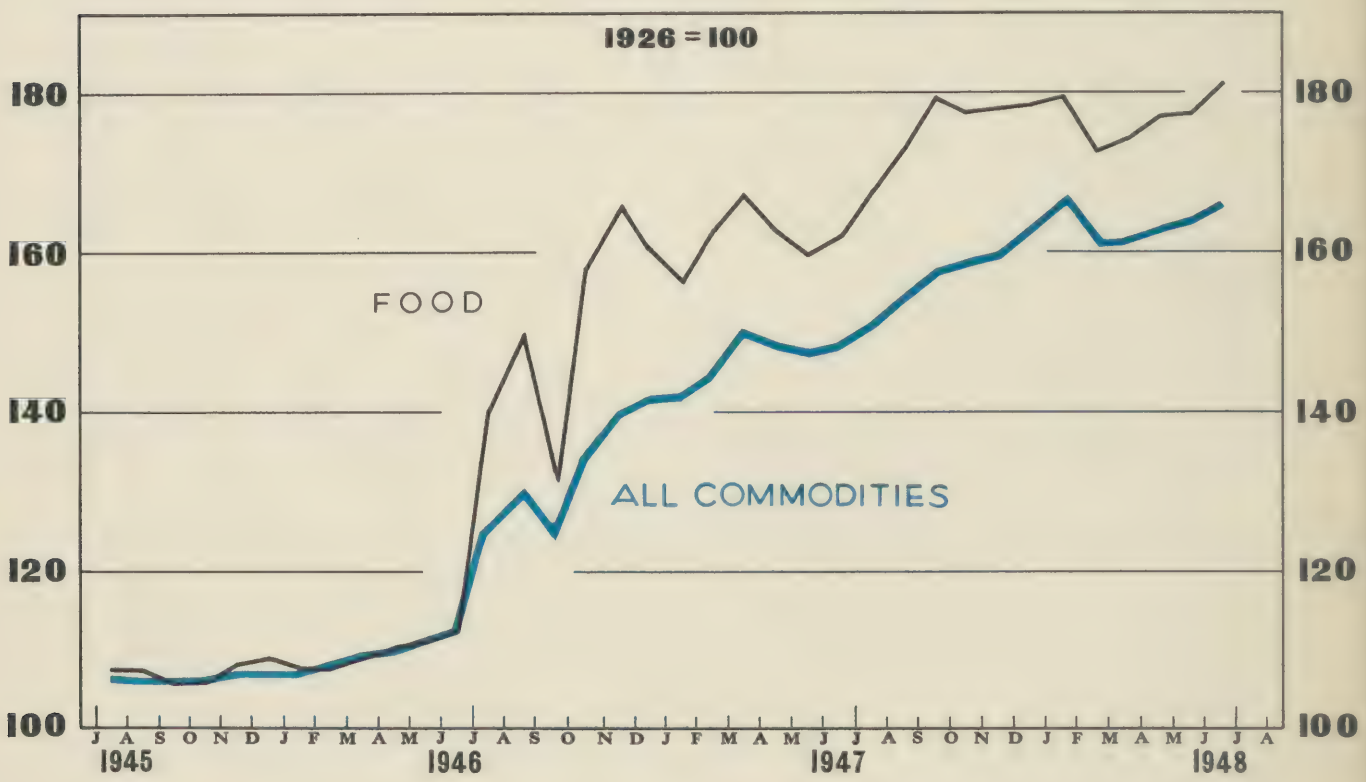
The executive budget is the primary tool of government for securing economy, efficiency, and adequacy in government services. The actual attainment of those objectives rests upon the operating agencies. The efficient agency will produce the desired results through a well-planned and well-executed program which is based on a full knowledge and understanding of the problems in hand. The proof of efficiency and economy rests on the ability of the operating agency to demonstrate that its obligations for service have been fulfilled in accordance with a well-constructed and well-administered budget. The best hope of getting that kind of budget springs from a precise knowledge of all the essential facts. Therein lies the solution to the problem of budgeting for mental hospitals.

▲ ▲ ▲

Findings

SUMMARY AND TABLES

The Upward March of Wholesale Prices



SOURCE OF DATA:
U. S. BUREAU OF LABOR STATISTICS WHOLESALE PRICE INDEX

SUMMARY OF STATE PRACTICES AND THE DATA

THE questionnaire used in the survey is reproduced in Appendix C. The answers and information received from the forty-eight states have been tabulated and appear in the tables that follow this discussion. The table titles are phrased as questions and the answers by the states are indicated in the body of the table. Space limitations and considerations for a logical presentation have dictated a rewording and re-arrangement of the original questions on the questionnaire. However, the correspondence between questionnaire and tables should be quite evident.

The mental hospital population of a given state is not a yardstick of mental illness but must be taken simply as a measure of the extent that hospitalization occupies in the state mental health program. The size of the hospital problem in each state is described by the first table. The figures reported cover both the mentally ill and the mentally deficient. While in the country as a whole we find one state mental hospital patient among every 263 inhabitants, wide departures from this ratio are found. One state has hospitalized as many as one out of every 152 inhabitants. At the other extreme is a state with only one patient out of every 753 inhabitants. In the latter state, there are county asylums which also take care of mental patients.

ADMINISTRATIVE CONTROL OF HOSPITALS

The individual differences of the states are emphasized in the many types of administrative arrangements under which the mental hospitals are operated. There are two basic types of administrative agencies for mental hospitals:

a) the executive department as found in 20 states, and
b) boards and commissions as found in 28 states.

Within each of these types we find further variety in the kinds of responsibility delegated to the agency. In general, there are three patterns for the agencies:

1) Agencies responsible for a general social welfare program administer 83 mental hospitals in 12 states;
2) Agencies responsible for operating a group of several types of state institutions administer 69 mental hospitals in 17 states;
3) Agencies solely responsible for a state mental hygiene program administer 109 mental hospitals in 19 states.

The number of states shown as belonging to each of these three patterns is only approximate because the information at hand does not clearly indicate the full administrative organization in each state. Also, there are some states whose organization is not fully covered by any one of these categories.

APPROPRIATION PRACTICES

The states further indicate their individuality by the way their appropriations run.

Biennial Appropriations:

ending June 30, 1948	3 states
ending March 31, 1949	2 "
ending May 31, 1949	1 "
ending June 30, 1949	31 "
ending August 31, 1949	1 "
ending September 30, 1949	1 "
ending December 31, 1948	1 "
	40 states

Annual Appropriations:

ending June 30, 1948	7 states
ending March 31, 1948	1 "
	8 states

All told, 44 of the states make individual budgets for each hospital and 38 of these also

make separate appropriations to the hospitals. This means in effect that the overwhelming majority of the states find it advisable to give formal recognition to each institution by considering each as a more or less separate operating unit. In a number of states separate institutional budgets and appropriations become rather meaningless because of the many transfers of goods and services, as well as funds, from one institution to another. As a result, it becomes difficult to assess each institution's actual cost of operation and the individual budgets are more symbolic than real.

COSTS OF MAINTENANCE—BASIS FOR THE REPORTS

In some of its cost surveys on state institutions the U. S. Department of Commerce* has tried to get comparability from state to state by asking that expenditures be reported in specific categories, such as "salaries and wages," "purchased provisions," "fuel, light and water," and "other maintenance." The present survey has taken the other alternative of asking each state to report the figure that it considers as its per capita cost of maintenance and the elements of that cost. This required an additional series of questions to learn how the various expenses were charged and how the per capita costs were calculated. The replies show a great deal of agreement as to what should be considered as operating cost.

Almost all states report that their cost figures

a) include all items of current expense, and
b) exclude the cost of permanent improvements of the plant.

Over two-thirds of the states report that the replacement cost of equipment is included in their cost figures and 22 states also include the cost of special repairs and of making additions to present equipment. Considerable disagreement on how best to allocate the cost of equipment and special repairs is inevitable under government accounting practice. This will be the case as long as governments do not adopt the business practice whereby depreciation charges are made against the aging of permanent equipment and plant. It might be expected that the states which included equipment expense in their maintenance cost would have consistently higher per capita costs than the 26 states which excluded equipment in their calculations. Actually, the 26 states excluding equipment costs have a higher average cost than the others. However, it is likely that this curious situation is largely due to the fact that it was difficult to purchase enough equipment during the year 1946-47 to really affect the cost structure. Moreover, this group of 26 states largely consists of the more populous states. In fact, the hospital population for that particular group of states amounted to almost 60% of the mental hospital population in the country. Consequently, no valid conclusion can be drawn from these data as to the actual effect of omitting the cost of equipment in calculating per capita costs.

In order to learn if reimbursements for the care of some of the patients had any effect on reported costs, the states were questioned on the point. The practices reported are summarized on page 30 and the pertinent comments of thirty-three states follow on pages 31-34. As far as the per capita costs are concerned, reimbursement had little or no effect on the figures reported because receipts from reimbursements are almost without exception taken into general income. It had been expected that some states might be excluding from their per capita costs a part of the maintenance expense for patients on whom reimbursements were received.

In considering per capita costs it was also necessary to learn the population base employed by each state. Almost all states figure their costs on the basis of average daily patient population. There is more disagreement as to what types of patients are to be counted. About one-third of the states report that they count as part of the institutional population those who are receiving "out patient" care from the hospital. By and large, the method of counting population has not varied enough to render the reported per capita costs unsuitable for comparison.

COSTS OF MAINTENANCE — FINDINGS

The 261 mental institutions have a total population of 538,969. Individual hospital popu-

*See U. S. Department of Commerce, Bureau of the Census, reports on mental institutions: Series P-85 No. 16 and Series MP No. 13.

lations run from as low as 52 to a high of 8,737 patients. Per capita costs also vary widely—one hospital reporting a daily cost of only 64 cents per patient as compared to $16.47 at the other extreme. Although per capita cost figures were not available from 15 out of the 261 hospitals, the inclusion of data from the missing 15 could do nothing to simplify the confused pattern shown by the costs reported.* The average-size hospital has a little over 1,800 patients and the average cost for hospitals about that size is $1.26 per patient. Yet the average per patient cost for all the hospitals is $1.44. These disparities in the various averages demonstrate that it is virtually impossible to arrive at any good concept of what should be a standard per capita cost just in terms of hospital size. The greatest uniformity to be observed among any group of hospitals over the country is among those with a patient population over 4,000. There are thirty such hospitals in thirteen states on which cost data were reported. The thirteen states are well scattered throughout the entire country. It is, therefore, interesting to observe that there is only one dollar's difference between the lowest and highest costs reported, while the middle cost for the group is $1.41, very near the nationwide average for all the reporting hospitals. Again the geographic distribution of high and low cost hospitals in that group corresponds to expectation with the lowest costs in the Deep South and the highest in the North.

The greatest cost spread, as well as the highest costs, are reported in a group of 25 hospitals, each with less than 500 patients. In this group of 25 small hospitals there are 12 that report a per capita cost of $2.00 or more. The entire group of hospitals having per patient costs of over $2.00 a day (27 altogether) constitute quite a special class of institutions. New York has eight such hospitals and their high cost as compared to the other New York hospitals is due to larger expenditures for personal services. The two highest per capita costs are at the Psychopathic Hospital and the Psychiatric Institute. Ohio has six hospitals in the high cost group and three of them are receiving hospitals. Nine other states were represented in the over $2.00 group. In some of them the high cost is due to a small patient load. This was true in Florida where the hospital had been in operation for a period of a little over four months. In other states, the type of patient had a predominant influence on costs. Connecticut's two high cost institutions were training schools. Illinois' highest cost is at a hospital for the criminally insane. Minnesota's school for the educable feeble minded is its smallest institution and falls in the costliest group. Wisconsin has high costs at three of its five hospitals. This may be due to the fact that Wisconsin's state mental hospital program covers a highly selected group.

It is well to note that there are eleven states reporting a single hospital. Obviously, these eleven states have no opportunity to select patients by type as is done for mental hospital programs in some of the larger states. The importance of this is emphasized by Dr. M. A. Tarumianz, of Delaware State Hospital, who writes: "I would like to emphasize the fact that the per capita cost of the acutely ill and convalescent cases is $5.50 per day. When such cases are not considered in per capita cost, then we can expect the cost figure to drop from $2.10 per day to $1.65 per day."

Geographic location should, on the face of it, have an important bearing on the costs reported, but the results are somewhat inconclusive. Over half of the hospitals are in the northeastern section of the country — in the New England, Middle Atlantic, and East North Central Regions. In this area the average cost is above the national average. This is to be expected because the populous states have developed more elaborate programs with specialized hospital facilities. Nevertheless, in this group of states, there are some hospitals whose per diem cost is as low as or lower than in low cost hospitals of the regions where the average itself is low. The Mountain and Pacific sections of the country operate about 12% of the state mental hospitals. The average cost for this group of mental hospitals in the West is the same as the national average. About the only safe generalization is to observe that higher costs occur in those areas where they are best afforded, namely, the wealthier states of the North and the West.

*Figures presented on pages 35-37 are not in every case identical with those reported by the state. Per capita costs that were reported on a weekly, monthly, or annual basis were adjusted to a per diem basis. The state wide averages were calculated from the figures reported for the individual hospitals by the following formula: weighted average equals the sum of the products of the individual hospital population times its per capita cost divided by the total state hospital population.

COMMODITY COSTS

The starting point for this survey of mental hospital budgeting was concern over commodity costs in a time of rapidly rising prices. The price inflation has brought into sharp focus all the natural difficulties in arriving at sound estimates of the funds needed for commodities at state mental hospitals. Investigation has shown that an interpretation of the commodity problem could hardly be made without considering its relation to the entire budget problem. Accordingly, this study has been directed at the entire problem, but with a special and detailed emphasis on commodities.

A mental hospital budget may or may not carry a specific allocation for commodities as such. In any event, the budget cannot be constructed without making a decision on how much is to be allowed for the purchase of commodities because of the large proportion of total operating expense that is incurred by commodity purchases. A decision on how much to set aside for future purchases of commodities is complicated by having to anticipate future operating conditions as well as the effect of future prices. These and the many other problems on commodities made it necessary to ask the states in detail about their methods for estimating commodity needs and their methods of commodity procurement.

Answers to the question on how commodities are purchased revealed that the states quite generally have a centralized procurement scheme for institutional buying.* Only four states reported each institution as doing its buying on an individual basis. (Two of these states have only one institution, another has two, and the remaining state has three mental hospitals.) The replies do not clearly indicate the extent to which centralized supervision over purchases actually exists or is exercised. It appears that most of the replies attempt to give an idea of the actual purchasing practice rather than just the formal basis of procurement. This is evident from the fact that certain states, whose law requires all purchases (aggregating more than a trivial amount) be made through and by a state purchasing agent, have indicated that some purchasing is done directly by the institution. This reflects a fairly common practice, dictated by practical necessity, whereby the managing officer gets authorization to act for the central purchasing agent in certain circumstances. All in all, the variations in purchasing policy among the states do not appear sufficient to preclude state to state price comparisons.

A further indication of whether price comparisons would be feasible was sought by the question which asked the kind of price level assumed when the state took occasion to estimate its commodity prices. Here the replies prove quite inconclusive. Fifteen states consider their buying to be at wholesale prices, while another fifteen project from their "own level." Only six states derive their price estimates from cost accounting methods. The general conclusion from the entire group of answers is that the states are unable to definitely associate their prices with specific price standards.

FOOD PRICES

The circumstances just described remove any cause for surprise when viewing the actual prices reported on certain food commodities, tabulated on pages 40 and 41. The wide variation in prices to be observed there arises from many factors. It is first necessary to caution the reader that the prices shown in the table are not verbatim quotations of what the states reported. The reported prices were expressed for various units, particularly in the case of the perishables. One state reported lettuce prices by the pound, another by the crate. An attempt was made to prepare the table so that all prices would be properly related to the same unit of measurement. There is no way to know how successful this may have been.

Direct state to state comparisons are the more uncertain because there is no way of knowing what quality grades were selected for purchase. The grade of certain foods varies even at just one institution because of what may or may not be available on the market at time of purchase. Although the question asked for average prices in the three month period from July to September 1947, it is known that not all prices there quoted actually represent

* For further information on the question, see COUNCIL OF STATE GOVERNMENTS publication BX-268 (May 1947) "Purchasing by the States."

the market conditions of the period. This is because many states make a practice of buying certain items on a long-term contract at a fixed price. Note Massachusett's comment on this point.

Recognizing that differences in contract policies, in packaging, in specifications, etc., can cause substantial price variations from state to state, one could well expect even greater differences in prices than those reported by the 41 states supplying price information. Actually, it is not difficult to see that the states generally buy much the same type and quality of food for their hospitals. Also, the prices evidently range at a level somewhere between retail and wholesale market prices. The general price variations over the country are quite in accord with what is to be expected. States near major markets or producing areas tend to buy at lower prices than states not so favorably situated. The range of prices reported on staples is much narrower than on fruits and vegetables. A surprising stability is evident in the meat prices reported. This may in part be ascribed to similarity in the grade and type of meat cuts used in institutions coupled with the price standardization of the meat distribution system in the country.

There is reason to believe that the food items on which prices were asked make up over half of the food cost at almost any of the state hospitals. (In Illinois these items make up 70 per cent of total food expense.) The question was limited to food because it accounts for the major portion of all commodity expense while at the same time food prices generally show greater variability than the prices of other commodities.

Several states commented on the importance of home produced meats, milk, vegetables, etc., in the institutional food supply. Home production of food complicates the problem of arriving at actual food costs, even at a single institution. It is always necessary to measure the effect of home production on total food requirements when a substantial part of the total annual requirements are met in this way. In a hospital system there are never any two institutions that produce quite the same things or quite the same proportion of their needs. This makes it essential that some method of pricing and charging for home production be adopted so as to fully evaluate the requirements for food procurement. Therefore, most of the states have a scheme for valuing their home production. As can be seen in Table 42, only six states do not price the products from their institutional farms. More states (21) agree on assigning wholesale market prices to their production than on any other system of pricing. The comments demonstrate that there is real difficulty in assigning prices which will best reflect the value of institutional production in the picture of operations.

There is a similar problem for surplus commodities obtained gratis from the Federal government. Here we find less agreement on what the states do. Twelve states failed to reply to this question and sixteen answered "not priced." The others use the same sort of pricing policy on surplus commodities as they use on the products from their farms.

METHODS OF PROJECTING COMMODITY COSTS

The primary method of almost every state in deciding upon a budget figure for commodities is to take the past experience and make some sort of allowance for future price changes. Table 44 shows the base period employed by each state in making its budget estimates. A one year period is the preferred base in 19 states. The practices of the states are summarized on page 45 in the notes and comments. From the comment, it is evident that rule-of-thumb methods for projecting costs are the most popular. Systematic methods are used in relatively few states.

The majority of states report the use of some price index in making their estimates on what commodities will cost them. Most of these states (23) use their own index of prices, reflecting the general belief that the pricing of institutional commodities differs appreciably from the standard market indexes. Ten states use the BLS indexes, mostly to interpret economic trends. They evidently agree with California in the observation: "We have found a rather close correlation between state prices and the Bureau of Labor Statistics indexes."

The predominant position of food is evident throughout the commodity cost picture. Twenty-nine states report that their estimates for food are based on a regularly established diet schedule. States like Rhode Island, Pennsylvania, California, New Jersey, and New

York make especially effective use of their diet standards for planning and administering their food budgets. As an incidental part of this survey, information was gathered on diets and diet schedules. Summaries and evaluations of this material are given in Appendix B. These evaluations were independently made by a professional nutritionist in each of the following organizations: Illinois Department of Public Welfare, Illinois Department of Public Health, University of Illinois, and Iowa State College. The study of institutional diets clearly reveals that the important factor in selection and cost of diet is the type of food consumer. The policy pursued with regard to employee maintenance has a particularly important effect on the expenses incurred for food. This complicates the situation, because the cost of feeding employees is in effect a personal service cost and is bound up in personnel administration policy. In the feeding of patients, there is fairly substantial agreement on dietary standards for each major type of patient according to his age, activity, and disability.

RECENT EXPERIENCE WITH COMMODITY COSTS

The states were asked to report their experience in anticipating commodity costs with particular reference to food. Comparison was sought between the anticipation for 1947-48 as against 1946-47. The reports reflect the widely differing fiscal and operational policies pursued by the states. The answers were necessarily in so many different forms and represented so many different conditions that few reliable comparisons can be made from the figures reported other than to show up the great variety of situations. Some states reported only biennial appropriation totals for their anticipated figure. Some states based the estimates reported on 1947 experience, others on 1945-46 etc. Such differences in the base periods among the states made it next to impossible to obtain comparable kinds of reports. With these limitations in mind it is, nevertheless, significant that almost every state reports a substantial percentage increase for commodities in 1947-48 over the preceding fiscal year. The percentage increases range from 6 to 64 per cent with a median of 29 per cent.

During war time, standards of operation, particularly feeding, were somewhat abnormal as compared to peacetime. Also, in recent years there has been increased recognition of a need for improving the institutional regimen. As a result, it is apparent that after the War, most states took occasion to improve their standards of operation as soon as sufficient goods became available. However, only eleven states reported that diet improvement actually increased their commodity costs. Of these eleven, only six went so far as to estimate what additional funds would be required to bring about that diet improvement. Even more strangely, only five states reported that allowance had been made for a prospective increase in hospital population. Of these states only two undertook to explicitly estimate an additional commodity expense because of the prospective population increase. The fact that this part of the question was unanswered by so many states is plausible evidence that a great many of the states are not prepared to make specific allowances for changes in total hospital load. It is, of course, true that while there may be need to care for a greater patient population, the present facilities in most states are already filled to overflowing.

Twenty-three states were able to report a specific figure for the amount of increased expenditure anticipated for food. It is indicative of the differences in operating situations that such anticipation accounted for 17 to 86 per cent of the total increases specified for commodities. Since food constitutes the greater part of commodity expense, it is natural that the major share goes for food increases.

A specific question was asked as to how great a part of all commodities was estimated to be food. Among the states that made such an estimate it was found that, on the average, 54 per cent of all commodity expense went for food. There is greater consistency about this than for any other data elicited by the survey, because 24 out of the 33 states reported that food represented no less than 47 per cent nor more than 63 per cent of all commodity costs. It is likely that if all the states calculated their food costs so as to include the value of home production, there would be even closer agreement.

PER PATIENT FOOD COSTS

Since food is such a prominent factor in

the institutional cost picture, a special attempt was made to arrive at per patient food costs and an evaluation of the figures reported. The per diem per patient food costs are presented in the table on page 55. This table makes it evident that the food costs reported do not necessarily cover the total consumption of food. Consequently, the figures reported can act as only approximate measures of total food needs in most states. Oftener than not, the states do not include the value of their home produce and surplus commodities in calculating the food cost figure. In all those cases the cost reported merely reflects the needs for outright purchases of food.

The reported per diem food costs per patient range from a low of 25 cents to a high of 69.5 cents. The indicated failure to use uniform methods of calculation makes valid comparisons of these figures impossible. Also, it is to be recalled that the figures reported refer to the state's current appropriation. Accordingly, the reported figures may sometimes refer to one year and at other times to another year when prices and costs are entirely different. The only useful inferences from these data, then, are on the make-up of the reported costs. Twelve states indicated the amount of the food cost attributable to the value of home-produced food. We find that from 12 to 38 per cent of the total food cost is carried by home production. In addition, two states estimated the value of surplus commodities as part of the food cost. One of these states attributes 12.2 per cent to home produce and 3.5 per cent to surplus commodities. The other state attributes 13.0 per cent to home produce and 1.9 per cent to surplus commodities. The gist of the information on this question is that about three out of every five states budget on the basis of per capita food costs, but only two out of every five indicate they recognize that the value of home produce should be covered in food cost estimates. Even fewer states seem to be able to report the value of home produce. Surplus commodities as a factor in food cost estimates gets only a token recognition. Nevertheless, such information as is available indicates that surplus commodities and home production are far from negligible factors in the food cost situation. Because of this, it is essential to make precise provision for those factors if food costs are to be calculated on the basis of actual food consumption.

As a follow-up on the earlier question about anticipations for commodity cost increases, information was sought on the per patient increases allowed for food on a per diem basis. The results tabulated on page 56 show little that was not revealed by the previous question covered in the table on page 51. The significant fact is that few states carry such information on a per patient basis. Because of the great amount of food used for employees, the tendency is to deal mainly with meal costs irrespective of who eats the meal. While some states use per diem costs as a basis for making budget computations, they are very few in number.

The tabular chart on pages 58-59 gives further evidence of the variability in individual hospital costs. The chart covers the per diem food costs per patient at 154 hospitals. Although the states were requested to report on a per patient basis, in most cases the costs reported are costs per individual fed, where individuals include employees as well as patients. This makes state to state comparisons somewhat hazardous except as to the variability shown in the separate hospital systems. The fact that every state with more than one hospital shows up with quite a cost variation among its hospitals again emphasizes the intrinsic differences between mental hospitals.

SUMMARY

The information gathered on the various aspects of mental hospital budgeting and experience indicates that as yet no state has developed a scheme for handling the problems in a way that is generally applicable. The essentials of the most effective plans appear to be the following:

1) Have available at all times a precise knowledge of current operating costs.
2) Periodically revise estimations of future operating costs in the interest of effective budget administration so as to be better prepared for making the next budget.
3) Project cost estimations from a carefully selected base period that is representative of typical operating conditions and circumstances.
4) Make independent allowance for changes in standards and scope of program.

5) Make a decision as to what allowance should be made for changes in the price level. (Such a decision is preferably based on the latest price information and should be made as the final step in closing the budget preparation. This applies even when it is planned to take care of the effect of price changes entirely on a contingency basis.)

In considering the results obtained from this survey it is found that the striking absence of information on some points is as important, if not more so, than the actual data collected. There is no escaping the impression that the states, as a rule, are poorly equipped with the kind of factual information needed to cope with the many difficult problems of budgeting for the mental hospitals. The states that keep up a continuous review of the essential features of current operations are not only best prepared for budgeting, but actually have the best budget plans.

The ideas and information uncovered in this investigation are not new. The value of this study rests on how well it has placed the problems of budgeting in perspective and how far these often fragmentary results can be used in getting at the full situation. Finally, the sort of idea-interchange brought about by assembling the opinions of budget officials on their own immediate problems, offers stimulus, as well as suggestions for improving the effectiveness of mental hospital budgeting in particular and state budgeting in general.

THE NUMBER OF MENTAL PATIENTS IN STATE HOSPITALS COMPARED WITH THE STATE CIVILIAN POPULATION

STATE	State Civilian Population in 1947*	Number of State Mental Hospitals	Resident Population of Mental Hospitals**	Ratio of Hospital Residents to State Civilian Population
1. New York	14,066,000	26	92,679	1 - 152
2. Pennsylvania	10,267,000	21	42,174	1 - 243
3. California	9,751,000	10	32,191	1 - 303
4. Illinois	8,188,000	13	41,798 (a)	1 - 196
5. Ohio	7,764,000	19	29,768	1 - 261
6. Texas	7,044,000	8	16,858	1 - 418
7. Michigan	6,238,000	11	21,770	1 - 287
8. Massachusetts	4,713,000	15	27,992	1 - 168
9. New Jersey	4,391,000	7	15,587	1 - 282
10. Indiana	3,856,000	8	12,827	1 - 301
11. Missouri	3,852,000	6	10,542	1 - 365
12. North Carolina	3,679,000	5	8,909	1 - 413
13. Wisconsin	3,281,000	5	4,355	1 - 753
14. Georgia	3,208,000	1	8,895	1 - 361
15. Tennessee	3,073,000	4	6,843	1 - 449
16. Virginia	2,975,000	6	11,324	1 - 263
17. Minnesota	2,891,000	10	14,339	1 - 202
18. Alabama	2,817,000	3	6,834	1 - 412
19. Kentucky	2,757,000	5	7,210	1 - 382
20. Iowa	2,605,000	6	10,022	1 - 260
21. Louisiana	2,541,000	3	7,715	1 - 329
22. Florida	2,346,000	3	6,184	1 - 379
23. Oklahoma	2,302,000	6	8,978	1 - 256
24. Washington	2,195,000	5	8,858	1 - 248
25. Maryland	2,187,000	5	8,517	1 - 257
26. Mississippi	2,083,000	3	4,792	1 - 435
27. Connecticut	2,016,000	5	10,590	1 - 190
28. Kansas	1,903,000	3	5,075	1 - 375
29. Arkansas	1,902,000	1	4,803	1 - 396
30. South Carolina	1,897,000	2	5,805	1 - 327
31. West Virginia	1,848,000	5	4,447	1 - 416
32. Oregon	1,516,000	2	4,004	1 - 379
33. Nebraska	1,299,000	4	5,886	1 - 221
34. Colorado	1,142,000	4	5,400 (b)	1 - 211
35. Maine	910,000	3	3,777	1 - 241
36. Rhode Island	757,000	1	2,970	1 - 255
37. Arizona	649,000	1	1,255	1 - 517
38. Utah	635,000	1	1,149	1 - 553
39. South Dakota	561,000	1	1,651	1 - 340
40. North Dakota	552,000	2	3,060	1 - 180
41. New Hampshire	544,000	1	2,406	1 - 226
42. New Mexico	541,000	1	963	1 - 562
43. Montana	492,000	2	2,326	1 - 212
44. Idaho	488,000	3	1,704	1 - 286
45. Vermont	364,000	1	1,083	1 - 336
46. Delaware	293,000	2	1,744	1 - 168
47. Wyoming	270,000	1	583	1 - 463
48. Nevada	139,000	1	327	1 - 425
TOTAL	141,793,000	261	538,969	1 - 263

(a) Does not include Veterans Rehabilitation Center.
(b) Does not include Denver Psychopathic Institute.

* "Population Estimates, July 1, 1947": Current Population Reports, Department of Commerce, Bureau of the Census, October 12, 1947. Series P-25, No. 4.

** Population in hospitals for the mentally ill and mentally deficient in the latest fiscal year (see page 35.)

Note: The District of Columbia is not included.

Question: HOW DOES YOUR STATE MAKE ITS APPROPRIATIONS?

STATE	Biennially	Annually	Current appropriations run from	to	NOTES AND COMMENT
NEW ENGLAND					
Maine	X	..	July 1, 1947	June 30, 1949	
New Hampshire	X	..	July 1, 1947	June 30, 1949	
Vermont	X	..	July 1, 1947	June 30, 1949	
Massachusetts	..	X	July 1, 1947	June 30, 1948	
Rhode Island	..	X	July 1, 1947	June 30, 1948	
Connecticut	X	..	July 1, 1947	June 30, 1949	
MIDDLE ATLANTIC					
New York	..	X	April 1, 1947	Mar. 31, 1948	
New Jersey	..	X	July 1, 1947	June 30, 1948	
Pennsylvania	X	..	June 1, 1947	May 31, 1949	
EAST NORTH CENTRAL					
Ohio	(a)	..	Jan. 1, 1947	Dec. 31, 1948	(a) Ohio: "Ohio is the only state in which the fiscal year is the same as the calendar year."
Indiana	X	..	July 1, 1947	June 30, 1949	
Illinois	X	..	July 1, 1947	June 30, 1949	
Michigan	..	(b)	July 1, 1947	June 30, 1948	
Wisconsin	X	..	July 1, 1947	June 30, 1949	(b) Michigan: "Due particularly to economic conditions, appropriations have been made for one year only recently, and special session of the Legislature has been called to act on appropriations and other so-called emergency matters."
WEST NORTH CENTRAL					
Minnesota	X	..	July 1, 1947	June 30, 1949	
Iowa	X	..	July 1, 1947	June 30, 1949	
Missouri	..	(c)	July 1, 1947	June 30, 1948	
North Dakota	X	..	July 1, 1947	June 30, 1949	
South Dakota	X	..	Jul 1, 1947	June 30, 1949	
Nebraska	X	..	Ju 1, 1947	June 30, 1949	
Kansas	X	..	Jul 1 1947	June 30, 1949	(c) Missouri: " The funds presented to the Legislature by the Governor are for a two-year period but the Legislature may appropriate for one or two years as it sees fit."
SOUTH ATLANTIC					
Delaware	X	..	July 1, 1947	June 30, 1949	
Maryland	(d)	..	July 1, 1947	June 30, 1949	
Virginia	X	..	July 1, 1946	June 30, 1948	
West Virginia	X	..	July 1, 1947	June 30, 1949	
North Carolina	X	..	July 1, 1947	June 30, 1949	
South Carolina	..	X	July 1, 1947	June 30, 1948	(d) Maryland: " If approved by pending referendum, the 1950 budget will be annual."
Georgia	(e)	..	July 1, 1947	June 30, 1949	
Florida	X	..	July 1, 1947	June 30, 1949	(e) Georgia: "Current appropriations run from July 1, 1943 to June 30, 1944 and each and every fiscal year thereafter until repealed by law."
EAST SOUTH CENTRAL					
Kentucky	(f)	..	July 1, 1947	June 30, 1949	
Tennessee	X	..	July 1, 1947	June 30, 1949	
Alabama	(g)	..	Oct. 1, 1947	Sept. 30, 1949	
Mississippi	X	..	July 1, 1946	June 30, 1948	(f) Kentucky: "But the appropriation for each year of the biennial period is separate and there is no carry-over from one year to the next."
WEST SOUTH CENTRAL					
Arkansas	X	..	July 1, 1947	June 30, 1949	
Louisiana	X	..	July 1, 1946	June 30, 1948	
Oklahoma	X	..	July 1, 1947	June 30, 1949	
Texas	X	..	Sept. 1, 1947	Aug. 31, 1949	(g) Alabama: "We receive a check from the state of Alabama by the month. The appropriation is made on the basis per patient per week."
MOUNTAIN					
Montana	X	..	July 1, 1947	June 30, 1949	
Idaho	X	..	July 1, 1947	June 30, 1949	
Wyoming	X	..	April 1, 1947	Mar. 31, 1949	
Colorado	X	..	July 1, 1947	June 30, 1949	
New Mexico	X	..	July 1, 1947	June 30, 1949	
Arizona	X	..	July 1, 1947	June 30, 1949	
Utah	X	..	July 1, 1947	June 30, 1949	
Nevada	X	..	July 1, 1947	June 30, 1949	(h) California: "By constitutional amendment in November 1946, the Legislature meets annually and budgets and appropriations are every year."
PACIFIC					
Washington	X	..	April 1, 1947	Mar. 31, 1949	
Oregon	X	..	July 1, 1947	June 30, 1949	
California	..	(h)	July 1, 1947	June 30, 1948	
TOTAL	40	8			

Question: HOW DOES YOUR STATE HANDLE BUDGETS AND APPROPRIATIONS FOR STATE MENTAL HOSPITALS?

STATE	For each hospital separately		For hospitals as a group		No specific allocation to hospitals		NOTES AND COMMENT
	Budget	Appropriation	Budget	Appropriation	Budget	Appropriation	
NEW ENGLAND							
Maine	X	X	..	..	..	..	
New Hampshire	X	X	..	..	..	..	
Vermont	X	X	..	..	..	..	
Massachusetts	X	X	..	..	..	..	
Rhode Island	X	X	..	..	..	..	
Connecticut	X	X	..	..	..	..	
MIDDLE ATLANTIC							
New York	X	X	..	..	..	..	
New Jersey	X	X	..	..	..	..	
Pennsylvania	X	..	..	X	..	..	
EAST NORTH CENTRAL							
Ohio	X	..	..	X	..	..	
Indiana	X	X	..	..	..	..	
Illinois	X	..	..	X	..	..	
Michigan	X	X	..	..	..	..	
Wisconsin	..	..	..	..	(a)	(a)	(a) Wisconsin: "Requests are made by institutions. Appropriations for all institutions are supervised by Department of Public Welfare; they are made in a lump sum to the Department and are used at institutions as deemed necessary by the Department."
WEST NORTH CENTRAL							
Minnesota	X	X	..	..	..	..	
Iowa	X	X	..	..	..	..	
Missouri	X	X	..	..	..	..	
North Dakota	X	X	..	..	..	..	
South Dakota	X	X	..	..	..	..	
Nebraska	X	..	..	..	..	(b)	(b) Nebraska: "Allotment made by Department to each hospital."
Kansas	X	X	..	..	..	..	
SOUTH ATLANTIC							
Delaware	X	X	..	..	..	..	(c) Kentucky: "The appropriation for maintenance and operation is made in a lump sum for five institutions without any breakdown as to institutions or classifications."
Maryland	X	X	..	..	..	..	
Virginia	X	X	..	..	..	..	
West Virginia	X	X	..	..	..	..	
North Carolina	X	X	..	..	..	..	
South Carolina	X	X	..	..	..	..	
Georgia	X	..	..	X	..	..	
Florida	..	..	X	X	..	..	(d) Texas: "The Board of Control is the governing agency for all eleemosynary institutions. These include not only the mental hospitals but also various other institutions. At present there are a total of twenty-five such institutions under the Board's direction. The Legislature has given the Board authority to transfer funds from one institution to another whenever necessary. This authority is so broad that in effect it amounts to a lump sum appropriation to the Board for the support of all institutions."
EAST SOUTH CENTRAL							
Kentucky	..	..	..	(c)	(c)	..	
Tennessee	X	X	..	..	..	..	
Alabama	X	X	..	..	..	..	
Mississippi	X	X	..	..	..	..	
WEST SOUTH CENTRAL							
Arkansas	X	X	..	..	..	..	
Louisiana	X	X	..	..	..	..	
Oklahoma	X	X	..	..	..	..	
Texas	X	..	..	(d)	..	..	
MOUNTAIN							
Montana	X	X	..	..	..	..	
Idaho	X	X	..	..	..	..	
Wyoming	X	X	..	..	..	..	
Colorado	X	X	..	..	..	..	
New Mexico	..	..	X	X	..	..	
Arizona	X	X	..	..	..	..	
Utah	X	X	..	..	..	..	
Nevada	X	X	..	..	..	..	
PACIFIC							
Washington	X	X	..	..	..	..	
Oregon	X	X	..	..	..	..	
California	X	X	..	..	..	..	
TOTAL	44	38	2	8	2	2	

Question: HOW DO YOU CALCULATE PER CAPITA COST FOR MAINTENANCE -- AS TO POPULATION BASE?

STATE	Do you divide total cost by average daily population?		Does "average daily population" EXCLUDE Patients in convalescent care				Out-patients?		NOTES AND COMMENT
			Inside the institution?		Outside the institution?				
	Yes	No	Yes	No	Yes	No	Yes	No	
NEW ENGLAND									
Maine	X	..	..	X	X	..	X	..	
New Hampshire	X	..	..	X	(a)	..	..	X	(a) New Hampshire: "Patients on parole are excluded."
Vermont	X	..	X	..	..	X	..	X	
Massachusetts	X	..	..	X	X	..	X	..	
Rhode Island	X	..	X	..	..	X	..	X	(b) New York: "Yes, those in boarding houses are excluded. Our Mental Hygiene Law describes a paroleeas on 'convalescent status'. The answers to the question on patients in convalescent care outside the institutions refers to paroled patients who are carried on the institution records for one year after date of parole."
Connecticut	X	..	..	X	..	X	X	..	
MIDDLE ATLANTIC									
New York	X	..	..	X	(b)	..	X	..	
New Jersey	X	..	..	X	X	..	X	..	
Pennsylvania	X	..	..	X	..	X	X	..	
EAST NORTH CENTRAL									
Ohio	X	..	..	X	X	..	X	..	
Indiana	X	..	..	X	X	..	X	..	
Illinois	X	..	..	X	X	..	X	..	
Michigan	(c)	..	..	X	X	..	X	..	(c) Michigan: "Yes, per capita cost is all on usage basis."
Wisconsin	X	..	..	X	X	..	X	..	
WEST NORTH CENTRAL									(d) Tennessee: "We do not have out patients."
Minnesota	X	..	..	X	X	..	X	..	
Iowa	X	..	..	X	X	..	X	..	
Missouri	X	..	..	X	X	..	X	..	(e) Alabama: "No, our appropriation is based on the number of patients that are indigent on our books as of the last day of the month. We receive a check from the State by the month. Our appropriation is made on the basis per patient per week."
North Dakota	X	..	..	X	X	..	X	..	
South Dakota	X	..	..	X	X	..	X	..	
Nebraska	X	..	..	X	..	X	..	X	
Kansas	X	..	..	X	X	..	X	..	
SOUTH ATLANTIC									
Delaware	X	..	..	X	X	..	X	..	
Maryland	X	..	X	..	..	X	..	X	
Virginia	X	..	..	X	X	..	X	..	(f) Mississippi: "We do not use this system."
West Virginia	X	..	..	X	..	X	..	X	
North Carolina	X	..	..	X	X	..	X	..	
South Carolina	X	..	..	X	X	..	X	..	(g) Wyoming: "No, we divide total expenditures by total average cost days."
Georgia	X	..	X	..	..	X	..	X	
Florida	X	..	..	X	X	..	X	..	
EAST SOUTH CENTRAL									(h) Nevada: "We do not have out patients."
Kentucky	X	..	X	..	..	X	..	X	
Tennessee	X	..	..	X	X	..	(d)	..	
Alabama	..	(e)	..	X	X	..	X	..	(i) California: "Paroled patients, out-patients,and patients boarded out with families, are financed from appropriations other than State hospital support appropriations. Such costs are not reflected in per capita costs."
Mississippi	X	..	..	X	..	X	(f)	..	
WEST SOUTH CENTRAL									
Arkansas	X	..	..	X	..	X	..	X	
Louisiana	X	..	X	..	..	X	..	X	
Oklahoma	X	..	X	..	X	..	X	..	
Texas	X	..	X	..	..	X	..	X	
MOUNTAIN									
Montana	X	..	X	..	..	X	..	X	
Idaho	X	..	..	X	..	X	..	X	
Wyoming	..	(g)	..	X	X	..	X	..	
Colorado	X	..	..	X	X	..	X	..	
New Mexico	X	..	..	X	X	..	X	..	
Arizona	X	..	..	X	X	..	X	..	
Utah	X	..	X	..	..	X	..	X	
Nevada	X	..	..	X	X	..	(h)	..	
PACIFIC									
Washington	X	..	..	X	X	..	X	..	
Oregon	X	..	..	X	X	..	X	..	
California	X	..	..	X	X	..	(i)	..	
TOTAL	46	2	10	38	32	16	34	14	

Question: HOW DO YOU CALCULATE PER CAPITA COST FOR MAINTENANCE -- AS TO CLASSES OF EXPENSE INCLUDED?

STATE	Are you using Department of Commerce classification? Yes	No	Do your per capita cost figures include: All operating expenses? Yes	No	Permanent improvements? Yes	No	Equipment purchases? Yes	No	NOTES AND COMMENT
NEW ENGLAND									
Maine #			X	..	X	..	X	..	
New Hampshire	X	..	X	..	..	X	X	..	
Vermont	X	..	X	..	..	X	X	..	
Massachusetts	..	X	X	..	..	X	X	..	
Rhode Island	..	X	X	..	..	X	(a)	..	
Connecticut	..	X	X	..	..	X	..	X	
MIDDLE ATLANTIC									
New York	..	X	X	..	..	X	..	X	
New Jersey	..	X	X	..	..	X	(b)	..	
Pennsylvania	..	X	(c)	..	..	X	..	X	
EAST NORTH CENTRAL									
Ohio	..	X	X	..	..	X	X	..	
Indiana	..	X	X	..	..	X	..	X	
Illinois	..	X	X	..	..	X	X	..	
Michigan	..	X	X	..	..	(d)	(d)	..	
Wisconsin	..	X	X	..	..	X	(e)	..	
WEST NORTH CENTRAL									
Minnesota	..	X	X	..	..	X	X	..	
Iowa #			X	..	..	X	..	X	
Missouri	..	X	X	..	..	X	..	X	
North Dakota	..	X	X	..	..	X	(f)	..	
South Dakota	..	X	X	..	X	..	X	..	
Nebraska	..	X	X	..	..	X	..	X	
Kansas #			X	..	..	X	(g)	..	
SOUTH ATLANTIC									
Delaware	X	..	X	..	..	X	(h)	..	
Maryland	..	X	X	..	..	X	X	..	
Virginia	..	X	X	..	..	X	(i)	..	
West Virginia	..	X	X	..	..	X	..	X	
North Carolina	..	X	X	..	..	X	(j)	..	
South Carolina #			X	..	..	X	X	..	
Georgia	..	X	X	..	..	X	X	..	
Florida	..	X	X	..	..	X	(k)	..	
EAST SOUTH CENTRAL									
Kentucky	..	X	X	..	..	X	..	X	
Tennessee #			X	..	..	X	(l)	..	
Alabama	..	X	X	..	(m)	..	(m)	..	
Mississippi	X	..	X	..	X	..	X	..	
WEST SOUTH CENTRAL									
Arkansas	..	X	X	..	..	X	..	X	
Louisiana	X	..	X	..	..	X	..	X	
Oklahoma	..	X	X	..	..	X	(n)	..	
Texas	..	X	..	X	..	X	X	..	
MOUNTAIN									
Montana #			X	..	..	X	(o)	..	
Idaho	..	X	X	..	(p)	..	X	..	
Wyoming	..	X	X	..	X	..	X	..	
Colorado	..	X	X	..	..	X	X	..	
New Mexico	..	X	X	..	..	X	(q)	..	
Arizona	..	X	X	..	..	X	..	X	
Utah	..	X	X	..	..	X	X	..	
Nevada	..	X	..	(r)	..	X	X	..	
PACIFIC									
Washington	..	X	X	..	..	X	(s)	..	
Oregon	..	X	X	..	..	X	..	X	
California	(t)	..	X	..	..	X	(t)	..	
TOTAL #	6	36	46	2	6	42	35	13	

No answer on Department of Commerce classification (6 states).

(a) Rhode Island: "Replacements."

(b) New Jersey: "Replacements."

(c) Pennsylvania: "Excludes allowance for depreciation.

(d) Michigan: "Replacements."

(e) Wisconsin: "Replacements."

(f) North Dakota: Replacements and certain additional equipment.

(g) Kansas: "Replacements."

(h) Delaware: "Replacements."

(i) Virginia: "Replacements."

(j) North Carolina: "Yes, when equipment is purchased under the biennial maintenance budget."

(k) Florida: "Replacements."

(l) Tennessee: "Most of these items were paid from the Special Improvement Fund."

(m) Alabama: "Yes, where paid for from weekly per capita costs."

(n) Oklahoma: "Replacements."

(o) Montana: "Replacements,"

(p) Idaho: "Yes, minor. We made no permanent improvements--nothing over $10,000."

(q) New Mexico: Yes, when included in maintenance costs.

(r) Nevada: "Travel and transportation both are included in their separate appropriations."

(s) Washington: "Replacements"

(t) California: "The Commerce Department reflects new equipment under expenditures for improvements, whereas we charge new equipment to maintenance unless it is a major item or is new or replacement construction. For instance, if additional beds are required at the existing plant, such purchases will be charged to support. If, however, a new ward building were to be constructed, the initial equipment would be charged to improvements. Repairs to facilities are normally included in maintenance costs. However, extraordinary repairs or extensive maintenance items, which have been deferred for a long period of time, may be classed as capital outlay."

Question: HOW DO YOU CALCULATE PER CAPITA COST FOR MAINTENANCE

STATE	ITEMS OF EXPENSE INCLUDED IN COST FOR MAINTENANCE										
	salaries and wages	food	clothing and clothing material	household, laundry, etc.	medical, surgical, laboratory etc.	farm and garden expenses	fuel, light, power, water	traveling expense	automotive expense	printing and advertising	rentals
NEW ENGLAND											
Maine	X	X	X	X	X	..	X	X	X	X	X
New Hampshire	X	X	X	X	X	X	X	X	..	..	..
Vermont	X	X	X	X	X	X	X	X	X	X	X
Massachusetts	X	X	X	X	X	X	X	X	X	X	X
Rhode Island	X	X	X	X	X	X	(a)	X	X	X	X
Connecticut	X	X	X	X	X	X	X	X	X	X	X
MIDDLE ATLANTIC											
New York	X	X	X	X	X	X	X	X	X	X	X
New Jersey	X	X	X	X	X	X	X	X	X	X	X
Pennsylvania	X	X	X	X	X	X	X	X	X	X	X
EAST NORTH CENTRAL											
Ohio	X	X	X	X	X	X	X	X	X	X	X
Indiana	X	X	X	X	X	X	X	X	X	X	X
Illinois	X	X	X	X	X	X	X	X	X	X	X
Michigan	X	X	X	X	X	X	X	X	X	X	X
Wisconsin	X	X	X	X	X	X	X	X	X	X	X
WEST NORTH CENTRAL											
Minnesota	X	X	X	X	X	X	X	X	X	X	X
Iowa	X	X	X	X	X	X	X	X	X	X	X
Missouri	X	X	X	X	X	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X	X	X	X	X	X
Nebraska	X	X	X	X	X	X	X	X	X	X	X
Kansas	X	X	X	X	X	X	X	X	X	..	X
SOUTH ATLANTIC											
Delaware	X	X	X	X	X	X	X	X	X	X	X
Maryland	X	X	X	X	X	X	X	X	X	X	X
Virginia	X	X	X	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	X	X	X	X
North Carolina	X	X	X	X	X	X	X	X	X	X	X
South Carolina	X	X	X	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X	X	X	X
Florida	X	X	X	X	X	X	X	X	X	X	X
EAST SOUTH CENTRAL											
Kentucky	X	X	X	X	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	X	X	X	X	X
Alabama	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X	X	X	X	X	..
WEST SOUTH CENTRAL											
Arkansas	X	X	X	X	X	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X	X	X	X	X	X
Oklahoma	X	X	X	X	X	X	X	X	X	X	X
Texas	X	X	X	X	X	X	X	X	X	X	X
MOUNTAIN											
Montana	X	X	X	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X	X	X	X	X	..
Colorado	X	X	X	X	X	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X	X	X	X	X	X
Arizona	X	X	X	X	X	X	X	X	X	X	X
Utah	X	X	X	X	X	X	X	X	X	X	X
Nevada	X	X	X	X	X	X	X	X	X	X	X
PACIFIC											
Washington	X	X	X	X	X	X	X	X	X	X	..
Oregon	X	X	X	X	X	X	X	X	X	X	X
California	X	X	X	X	X	X	X	X	X	X	X
TOTAL	48	48	48	48	48	47	48	48	47	46	44

*minor

--AS TO SPECIFIC ITEMS OF EXPENSE INCLUDED?

ITEMS OF EXPENSE (continued)							STATE	NOTES AND COMMENT
com-munication	Repairs: labor	Repairs: material	Repairs: building	Equipment: replacement	Equipment: additional	Special Repairs		
							NEW ENGLAND	(a) Rhode Island: The state operates one mental hospital, situated with a group of other state institutions and serviced by a central power plant. Therefore no appropriations are made for fuel and power. Also, we have consolidated repair services in a 'Construction and Repair Unit' which supervises or performs all major repairs. These costs are not part of the over-all per capita."
X	X	X	X	X	X	X	Maine	
X	X	X	X	X	X	X	New Hampshire	
X	X	X	X	X	X	..	Vermont	
X	X	X	X	X	X	..	Massachusetts	
X	..	..	..	X	..	(a)	Rhode Island	
X	X	X	X*	..	..	X*	Connecticut	
							MIDDLE ATLANTIC	
X	X	X	X	..	..	..	New York	
X	X	X	X	X	..	X*	New Jersey	
X	X	X	X	..	..	X	Pennsylvania	
							EAST NORTH CENTRAL	Michigan: "Includes insurance."
X	X	X	X*	X*	..	..	Ohio	
X	X	X	X	..	..	X	Indiana	
X	X	X	X	X	X	..	Illinois	
X	X	X	X	X	..	X*	Michigan	
X	X	X	X	X	..	..	Wisconsin	Wisconsin: "Includes occupational therapy, religion, and recreation."
							WEST NORTH CENTRAL	Minnesota: "Includes bonds and insurance, freight and express, hospital care, stationery and office supplies, non-state employee services, other contractual services."
X	X	X	X	X	X	..	Minnesota	
X	X	X	X	..	..	..	Iowa	
X	X	X*	..	..	..	..	Missouri	Missouri: "Includes maintenance of grounds."
X	X	X	X	X	X	..	North Dakota	
X	X	X	X	X	X	X	South Dakota	
X	X	X	X	..	..	..	Nebraska	
X	X	X	X	X	..	..	Kansas	
							SOUTH ATLANTIC	North Dakota: "Includes insurance and bonds, workmen's compensation insurance, Patients' Welfare, occupational therapy."
X	X	X	X	X	..	..	Delaware	
X	X	X	X	X	X	..	Maryland	
X	X	X	X	X	..	X	Virginia	
X	..	..	..	..	..	..	West Virginia	
X	X	X	(b)	(b)	(b)	(b)	North Carolina	South Dakota: "We include all expenses and expenditures except new buildings."
X	X	X	X	X	X	..	South Carolina	
X	X	X	X	X	..	X	Georgia	
X	X	X	X	X	..	..	Florida	
							EAST SOUTH CENTRAL	(b) North Carolina: "Items in permanent improvement appropriation are not included in per capita cost computations."
X	X	X	..	..	..	..	Kentucky	
X	(c)	(c)	(c)	(c)	(c)	..	Tennessee	
X	X	X	X	X	X	X	Alabama	South Carolina: "Includes all maintenance items except those paid from special appropriation for Permanent Improvements."
X	X	X	X	X	X	X	Mississippi	
							WEST SOUTH CENTRAL	
X	X	X	X	..	..	..	Arkansas	
X	X	X	X	..	..	..	Louisiana	
X	X	X	X	X	..	X	Oklahoma	Florida: "Includes all general maintenance costs. Cost of maintenance and productive departments are distributed."
X	..	X	X	X	X	..	Texas	
							MOUNTAIN	(c) Tennessee: "Most of these items were paid from the Special Improvement Fund."
X	X	X	X	X	..	..	Montana	
X	X	X	X	X	X	X	Idaho	Idaho: "Includes postage, freight, fidelity bonds, insurance premiums, dues, subscriptions, irrigation charges and assessments."
X	X	X	X	X	X	X	Wyoming	
X	X	X	X	X	X	X	Colorado	
X	X	X	X	X	X	X	New Mexico	
X	X	X	X	..	..	..	Arizona	
X	X	X	X	X	X	X	Utah	
X	X	X	X	X	X	X	Nevada	
							PACIFIC	
X	X*	X*	..	X	..	..	Washington	
X	X	X	X	..	..	X	Oregon	Oregon: "Includes special repairs if maintenance items."
X	X	X	X	X	X	X	California	
48	45	46	43	35	22	23	TOTAL	

*minor

Question: WHAT IS THE PRACTICE IN YOUR STATE WITH RESPECT TO

STATE	Are Your Institutions Reimbursed?					Do Your Cost Figures Include Reimbursements from:			
	Not at all	By local or county governments?		By paying patients?		local or county governments?		paying patients?	
		Yes	No	Yes	No	Yes	No	Yes	No
NEW ENGLAND									
Maine	X	..	..	..	..	..	..	..	..
New Hampshire	..	..	X	X	..	..	X	X	..
Vermont	..	..	X	X	..	..	X	..	X
Massachusetts	..	..	X	X	..	..	X	..	X
Rhode Island	..	..	X	X	..	..	X	..	X
Connecticut	..	X	..	X	..	..	X	..	X
MIDDLE ATLANTIC									
New York	..	..	X	X	..	..	X	..	X
New Jersey	..	X	..	X	..	..	X	..	X
Pennsylvania	..	..	X	X	..	..	X	..	X
EAST NORTH CENTRAL									
Ohio	X	..	..	..	..	..	..	..	..
Indiana	..	X	..	X	..	X	..	X	..
Illinois	X	..	..	..	..	..	..	..	..
Michigan	..	X	..	X	..	..	X	..	X
Wisconsin	X	..	..	..	..	..	..	..	..
WEST NORTH CENTRAL									
Minnesota	..	..	X	X	..	..	X	..	X
Iowa	..	X	..	X	..	..	X	..	X
Missouri	..	X	..	X	..	X	..	X	..
North Dakota	..	X	..	..	X	X	..	..	X
South Dakota	..	X	..	..	X	X	..	..	X
Nebraska	..	X	..	X	..	X	..	X	..
Kansas	..	..	X	X	..	..	X	X	..
SOUTH ATLANTIC									
Delaware	..	..	X	X	..	..	X	X	..
Maryland	X	..	..	..	..	..	..	..	..
Virginia	X	..	..	..	..	..	..	..	..
West Virginia	..	X	..	X	..	X	..	X	..
North Carolina	..	X	..	X	..	X	..	X	..
South Carolina	..	..	X	X	..	..	X	..	X
Georgia	X	..	..	..	..	..	..	..	..
Florida	..	..	X	X	..	..	X	X	..
EAST SOUTH CENTRAL									
Kentucky	..	..	X	X	..	..	X	X	..
Tennessee	..	X	..	X	..	X	..	X	..
Alabama	..	..	X	X	..	..	X	X	..
Mississippi	..	..	X	X	..	..	X	X	..
WEST SOUTH CENTRAL									
Arkansas	..	..	X	X	..	..	X	X	..
Louisiana	X	..	..	..	..	..	..	..	..
Oklahoma	..	..	X	X	..	..	X	X	..
Texas	..	..	X	X	..	..	X	X	..
MOUNTAIN									
Montana	..	X	..	X	..	..	X	..	X
Idaho	..	X	..	X	..	X	..	X	..
Wyoming	..	..	X	X	..	..	X	X	..
Colorado	..	X	..	X	..	X	..	X	..
New Mexico	..	..	X	X	..	..	X	X	..
Arizona	..	X	..	X	..	X	..	X	..
Utah	..	X	..	X	..	X	..	X	..
Nevada	..	X	..	X	..	..	X	..	X
PACIFIC									
Washington	..	..	X	X	..	..	X	..	X
Oregon	..	..	X	X	..	..	X	..	X
California	..	X	..	..	X	X	..	..	X
TOTAL	8	19	21	37	3	13	27	22	18

REIMBURSEMENT FOR PATIENT CARE?

NOTES AND COMMENT

SUMMARY

In general, the reimbursements did not appreciably affect the per capita costs reported. In some states reimbursements are paid into the General Fund and become another source of income for the state governments. Most states require some compensation for non-indigent patients but ten states commented that the total amounts of such reimbursement were small or even negligible.

Payments made from individual patient accounts at the institution generally are not included as an institutional expenditure when the account is set up for the purchase of clothing, additional comforts, or extra medical care for the patient concerned.

A number of states complain of the difficulty encountered in having to estimate the receipts from reimbursement before being able to determine the amount that will have to be appropriated. The best practice is to have all reimbursements paid into the General Fund without earmarking them specifically for institutional use.

Many states feel that low charges make collections easier and actually have a greater total yield than charging the full cost of care to all patients who have the ability to pay the full amount. Some of the more populous states are required to obtain reimbursements from non-indigent patients. For this they have found it necessary to establish quite elaborate collection mechanisms and also have had to make careful cost studies in order to establish reliable per capita costs on which to base the rates of reimbursement.

Less than half of the states receive reimbursement from local or county governments. No specific mention is made in the comments as to receipts from any but county governments. The questionnaire replies do not reflect what is done by local and county governments for mental patients because the question referred only to the operation of state-owned facilities. In Wisconsin, for example, county governments operate asylums for the mentally ill.

THIRTY-THREE STATES COMMENTED ON THIS QUESTION AS FOLLOWS:

Alabama: A small percentage of patients are pay patients. Payment for their board is so credited.

Arizona: Estimated collections from patients are used as a base in applying for biennial appropriations from legislature. We are allowed to use our patients' collections in operating the hospital. We have 275 patients paying maintenance. Patients' collections for last fiscal year amount to $72,000.

California: Relatives of patients may deposit with the superintendent of the institution funds to be held in trust for the purchase of miscellaneous items as desired by the patient, usually items of a personal nature. Such items may be clothing, miscellaneous foodstuffs, candies; but in the main, are minor in amount. In addition, considerable quantities of clothing are given to patients by relatives and societies as gifts from time to time, which in the aggregate amount to a considerable part of the patients' clothing needs. This results in State appropriations and costs for clothing being at the minimum, since such donations, gifts, etc., are not recorded as operating expenses of the institutions. Special medical services, principally dental, are furnished patients at the expense of relatives and friends. Such costs are not reflected in State per capita costs, but in the aggregate, the amount would not be significant.

Colorado: The amount of income received from paying patients for the state of Colorado as a whole is very small. In the Mental Defective Homes at Ridge and Grand Junction, Colorado, this contribution amounts to approximately $1,000 for each home. This in comparison to the total over-all cost as you can see has very little significance in determining the appropriation from general revenue. However, the Colorado State Hospital at Pueblo in which the population is much greater does receive considerable income from patients. During 1946 and 1947 this averaged $18,000 per month or a total of $216,000 for the fiscal year.

While the per capita cost to the state in this Institution varies from $41 to $54 per person, we have found that setting too high a rate for those who can make some payment increases the difficulty of collection. Accordingly we have set a patient's rate for those who can pay $30 per month and approximately 13% of the patients at the Colorado State Hospital have been able to pay for this charge. I might further state that the income to the Colorado State Hospital has varied and for the

Question: WHAT IS THE PRACTICE IN YOUR STATE WITH RESPECT TO

NOTES AND COMMENT

present biennium is up $4,000 per month due to some large payments that have been collected with the help of the Attorney General's office from various estates, etc.

Connecticut: Partial reimbursement made to Department of Public Welfare (reimbursement goes to General Fund). Contribution has no bearing on per capita cost.

Delaware: During the last year we had an average of 300 paying patients, of which 115 paid the full cost ranging from $3.00 to $6.50 per day. The total income during the past year from paying patients was $177,776.09 which is utilized for maintenance and care of the whole population.

Florida: Hospitals maintained by State appropriations. Income from paying patients and from sales and services by the Hospitals is paid into State Treasurer and held available for use by Hospitals. We have few paying patients.

Georgia: Entire cost paid by State.

Idaho: All funds of whatever source are considered in operating expense.

Illinois: Gifts from relatives of patients are not recorded as operating expenses of the institutions. Per capita cost figures reflect the amount paid by the State.

Indiana: The counties reimburse the state for the clothing used by the patients whose families or estates do not pay for their support at the mental institutions. For such non-paying patients each institution compiles the costs of the clothing items used by each patient, and a statement is filed with the Treasurer of State. The Treasurer of State bills the counties for the total amount due and the money received is deposited in the General Fund. Those patients whose families or estates are able to contribute to the support of the inmate, not exceeding five dollars per week, are requested to do so. At the time of admittance to the institution a questionnaire blank is sent to families of all patients asking if they are able to contribute to their support. If the answer is in the negative, nothing further is done; however, upon the death of the patient the Attorney General's office notifies the county clerk of the patient's death and an investigation is made to see if he had an estate. If the deceased leaves an estate, a claim is filed by the Attorney General against the estate at the rate not exceeding five dollars for each week of the patient's confinement at the institution. No county support is collected on paying patients.

It can be seen that the reimbursements do not affect the appropriation for operations of the various state institutions but serve only as additional revenue to the General Fund. Due to a sliding scale on the amount of individual support received for the patients' maintenance, it is very difficult to ascertain the number of paying patients. For the year 1945-46 the state received approximately $170,000 from the patients' families and $393,000 county support.

Iowa: The state appropriates from the General Fund the necessary funds to operate the institutions and the amount paid back by local government and by patients or their guardians is credited back to the State General Fund.

Kansas: In relation to the amounts paid by the guardian or relative in Kansas, we have some patients designated as private patients who pay a fee of $5.00 per week for maintenance. These fees are credited to the institution's fee fund and used for general operating expenses along with any other fee collections they might have.

The Legislature in making appropriations for the operation of our mental hospitals takes into consideration two factors: one, appropriations to be made from the state general fund; and, two, the appropriation to the institution of any moneys it collects from private patients or the sale of livestock or other commodities. In this connection the Legislature is guided by an estimate of the fee collections and expenditures to be made from fees. This estimate is furnished at the time budget material is submitted by the individual institutions.

Section 39-232 of the law provides recovery from patients able to pay on basis of not to exceed $5.00 per week. Billings are made quarterly.

Of the 1,845 total patient population at the Topeka State Hospital, 462 are deemed able to pay. Private patient payments are received regularly from 319, occasional payments from 38, and no payments from 105.

Kentucky: The mental institutions of Kentucky are maintained solely by the Commonwealth through appropriations made biennially by the General Assembly. This is all State money and local and county governments do not contribute anything in any way to the support of these institutions. The

REIMBURSEMENT FOR PATIENT CARE? *continued*

NOTES AND COMMENT

only supplement to the State appropriation is from the payment of board for the maintenance of patients by families who are able to pay and who are financially liable under our laws. The rate charged for the maintenance of a patient is $30.00 per month, and our collections from this source will run about $120,000.00 per year. This money is deposited in a revolving fund in the State Treasury and is subject to use for maintenance and operating costs in addition to the Legislative appropriation. In some cases the families and relatives of patients furnish clothing, but this is not a requirement as the State provides all necessities, including food, clothing, shelter and medical care.

Maine: Many patients are home furnished.

Michigan: The county from which a commitment is made bears the cost of the patient for the first year; after that they become state charges. County payments together with that received from private patients, are credited to the general fund and do not affect appropriations. Reimbursement from counties and private patients totaled approximately $2,500,000 during the year 1946-47.

Minnesota: Present law provides for charging families of mental patients who are financially able, $10 per month for the care of such patients; or the per capita cost if the patient has no dependents and his estate is able to pay. A 'rider' to the 1947 Deferred Building Law further provides for the payment of $10 per month by the county from which the person is committed. No collections have as yet been made from the counties. First billings are as of January, 1948.

Excepting income from the Swamp Land Trust Fund, all receipts of institutions and activities under the Division of Public Institutions, which are financed by Legislative appropriations, are deposited in the General Revenue Fund. Income from the Social Welfare, Diversified Labor, Endowment Fund, etc., are credited to the individual institution accounts.

Mississippi: Institutions are partially reimbursed by paying patients. The Legislature gave authority to charge patients.

Missouri: Institutions are partially reimbursed — approximately 25%. Contributions received by the various institutions are deposited in the state treasury for the credit of the respective institution. These funds can be spent only in accordance with appropriations made by the Legislature. It is estimated that the total contributions for the fiscal year ending June 30, 1948 will amount to approximately $1,260,000.

Nevada: All revenues coming from local governments or paying patients go directly into the general fund of the state and do not affect the appropriation for the hospital. The court committing the patient decides whether or not the patient is to be in indigent status and due to the complete lack of social workers in Nevada the large majority of patients are entered as indigents. Because any monies that are collected are not available for use by the hospital, plus the fact that the appropriations committee never takes into consideration funds that have been collected when making appropriations, there is very little incentive to make financially capable patients pay for treatment.

New Jersey: Counties contribute one half of per capita cost toward support of indigent patients. Few paying patients pay full rate.

New Mexico: Cost is partly paid from other than state sources.

New York: Responsible relatives and patients who are financially able are required to pay for maintenance in a state mental institution. The great majority of the patients so paid for are in the state hospitals. There is very little reimbursement for care of mental defectives.

A reimbursing agent and stenographer are assigned to each hospital from the central office of the Department of Mental Hygiene. It is the responsibility of the agent to determine the ability of the relatives or patient (through his committee) to pay for maintenance.

Each year a basic rate is established by the Commissioner of Mental Hygiene, the Director of the Budget and the Commissioner of Social Welfare. The rate is based on the expenditures for the preceding fiscal year. The rate for the year April 1, 1948 to March 31, 1949 is $75 per month.

By correspondence with relatives and committees, the agent in each hospital determines the rate of reimbursement. His recommendations as to the rate for each patient, together with financial statements and other data, are reviewed by the central office staff. For about 2/3 of the patients paid for, the bills are prepared and records kept in the institutions. For the 12 smaller hospitals, the billing and record keeping is done by the central office with IBM equipment. Agents in the hospitals

Question: WHAT IS THE PRACTICE IN YOUR STATE WITH RESPECT TO REIMBURSEMENT FOR PATIENT CARE? *continued*

NOTES AND COMMENT

on central billing are furnished with a statement of each account in their hospitals each month.

There are approximately 22,000 patients for whom reimbursement is made. This represents about 25% of the hospital patients. In the fiscal year ended March 31, 1948, the total reimbursement was $6,244,000. Reimbursement receipts are transferred by the Department to the State Treasury and have no effect on either the appropriation for institutions or the amounts available for expenditure.

North Carolina: Counties reimburse the institutions for inebriates and criminal insane only. Non-indigent patients reimburse the institutions.

Ohio: Some clothing is furnished by relatives. Only about 50 patients are on family care program.

Oklahoma: Our group of mental hospitals collect about $58,000 annually from paid patients or their custodians or relatives. This charge cannot exceed $25.00 per month but is only collected from families who are financially able to pay. Therefore, the hospital receives varied amounts based on ability to pay, but not to exceed $25.00 per month. In numerous cases no charge is made.

The estimated amount of these fees is deducted from the budget request for mental institutions, and the appropriation is made for the difference. Patient fees are deposited in the institutional fee fund and used for general maintenance of the institution.

The Budget Office is recommending a change in this procedure to the next session of the Legislature to require these fees to be deposited in the Treasury, and the appropriation made to maintain the institution including an estimate of such fees in the appropriation. This recommendation will be made since the present procedure requires the institution to base its budget on a very unreliable source of revenue.

Oregon: A charge of $25.00 per month is made for all insane and feebleminded patients. A charge of $65.00 per month is made for all tuberculosis patients. This amount is collected by the Board of Control from all those with the ability to pay. The amounts collected are turned into the General Fund from which appropriations are made. The amount of the collections does not in any way alter the per capita cost per day.

Pennsylvania: Appropriations are made to the several hospitals for a biennial period by the General Assembly. The patients in each hospital are classified as to their ability to pay into 'full pay', 'part pay' and 'indigent' patients. All patients, however, receive the same identical services and treatment. The total operating cost of each institution is computed monthly by including all items of cost except the addition of new capital equipment. The per capita daily cost for each month covering each hospital is then determined by dividing into the cost figure the total patient days for each month. Full pay patients are billed this full rate and part pay patients only such a fraction thereof as the Credit Department has previously determined they can pay. Such collections are then returned to general unappropriated revenue of the Commonwealth and do not revert to the credit of each institution.

Rhode Island: All payments received for board or care of patients are treated as general revenue of the state and have no bearing on the appropriation for, or expenditures of, the mental hospital.

In the fiscal year 1947 the total collection for payment of board was $116,942. For the fiscal year 1946, collections were $108,047. There was an average of approximately 3,000 patients in the fiscal year 1947. There were 461 accounts on which some payment was made during 1947.

South Carolina: We have a population today of 5,020, of which only 60 are classed as paying patients. For the first 9 months of the current year they have paid $24,058.48. All collections are to the General Fund of the State and are not to be added to our direct appropriation.

Texas: Money received from patients' board and treatment is deposited to the credit of each institution's local funds. These local funds are reappropriated to the institutions each year by the Legislature. Our total collections from pay patients for the fiscal year ended August 31, 1947, amounted to approximately $432,000.00 We have approximately sixteen hundred (1600) pay patients in our institutions.

Virginia: No legal requirement, negligible amount.

Wyoming: At the time of Court Commitment, if the patients' guardian or relatives are financially able to care for the patient, a price is set to be paid monthly. This amount is usually very small and these amounts are credited to the "Fund for Insane" and used for maintenance purposes.

Question: WHAT WERE THE PER CAPITA COSTS FOR MAINTENANCE IN YOUR LATEST FISCAL YEAR?

STATE	FIGURES FOR THE YEAR ENDING JUNE 30, 1947, WITH THE EXCEPTIONS AS NOTED, WERE:							NOTES AND COMMENT
	Average Daily		Number of Hospitals	Range between Hospitals				
	Resident population	Cost per patient		Average daily Population low	high	Average daily Cost per patient low	high	
NEW ENGLAND								
Maine	3,777	$1.52	3	1,073	1,528	$1.48	$1.55	
New Hampshire	2,406	1.90 (a)	1					
Vermont	1,083	1.18 (b)	1					
Massachusetts	27,992	1.58	15	1,234	2,844	1.38	1.80	
Rhode Island	2,970	1.20 (c)	1					
Connecticut	10,590	1.85	5	1,205	3,020	1.64	2.33	
MIDDLE ATLANTIC								
New York	92,679	1.80 (d)	26	57	8,737	1.34	16.47	
New Jersey	15,587	1.63	7	637	5,736	1.11	2.14	
Pennsylvania	42,174	1.37 (e)	21	250	6,044	1.12	1.94	
EAST NORTH CENTRAL								
Ohio	29,768	1.48 (f)	19	52	2,977	0.98	8.57	
Indiana	12,827	0.97	8	980	2,256	0.85	1.15	
Illinois	41,798	1.59 (g)	13	361	6,579	1.28	2.30	
Michigan	21,770	1.70	11	363	4,082	1.44	2.22	
Wisconsin	4,355	1.81	5	331	1,520	1.33	2.71	
WEST NORTH CENTRAL								
Minnesota	14,339	1.08	10	355	2,429	0.80	2.42	
Iowa	10,022	1.02	6	1,546	1,861	0.85	1.22	
Missouri	10,542	1.53	6	1,653	2,539	1.17	1.84	
North Dakota	3,060	(h)	2	see note				
South Dakota	1,651	1.02	1					
Nebraska	5,886	1.24	4	1,162	1,689	0.89	1.53	
Kansas	5,075	0.98	3	1,523	1,845	0.89	1.10	
SOUTH ATLANTIC								
Delaware	1,744	1.64	2	485	1,259	1.35	1.75	
Maryland	8,517	1.29	5	471	2,933	1.15	1.57	
Virginia	11,324	1.00	6	218	3,904	0.82	1.55	
West Virginia	4,447	0.89	5	313	1,803	0.78	1.06	
North Carolina	8,909	1.33	5	500	2,613	0.74	1.82	
South Carolina	5,805	1.23	2	963	4,842	1.05	1.27	
Georgia	8,895	0.93	1					
Florida	6,184	1.29 (i)	3	see note				
EAST SOUTH CENTRAL								
Kentucky	7,210	0.89	5	652	2,277	0.66	2.29	
Tennessee	6,843	0.76	4	717	2,224	0.69	0.83	
Alabama	6,834	1.13 (j)	3	see note				
Mississippi	4,792	0.86 (k)	3	370	3,697	see note		
WEST SOUTH CENTRAL								
Arkansas	4,803	1.20	1					
Louisiana	7,715	1.02	3	850	4,469	0.94	1.41	
Oklahoma	8,978	(l)	6	see note				
Texas	16,858	0.70 (m)	8	441	2,954	0.64	0.95	
MOUNTAIN								
Montana	2,326	1.39	2	504	1,822	1.33	1.62	
Idaho	1,704	1.05 (n)	3	429	654	0.70	1.29	
Wyoming	583	1.14 (o)	1					
Colorado	5,400	1.67 (p)	4	350	4,600	1.36	1.78	
New Mexico	963	1.42	1					
Arizona	1,255	1.64	1					
Utah	1,149	1.45	1					
Nevada	327	1.51	1					
PACIFIC								
Washington	8,858	1.54 (q)	5	705	2,544	1.33	1.76	
Oregon	4,004	1.06	2	1,340	2,664	0.98	1.10	
California	32,191	1.44	10	723	4,534	1.27	3.15	

(a) New Hampshire: "Gross $1.90; net $1.70."

(b) Vermont: Year ending June 30, 1946.

(c) Rhode Island: "This per diem cost figure is only an estimate. Under our budgetary and accounting system the cost of all the heat and power for all our institutions is chargeable to a separate unit of the government, and the cost of all major repairs is chargeable to another unit. There is no accurate breakdown as to what portion of the services and expenditures can be attributable to the one mental hospital."

(d) New York: Year ending March 31, 1947.

(e) Pennsylvania: Year ending May 31, 1947.

(f) Ohio: Year ending Dec. 31, 1947.

(g) Illinois: Does not include Veterans Rehabilitation Center.

(h) North Dakota: "Information not available."

(i) Florida: Does not include Florida Farm Colony for Feebleminded.

(j) Alabama: Year ending September 30, 1947. Average cost figure does not include Partlow State School.

(k) Mississippi: 3 quarters ending March 31, 1948. Average cost for only one of the three hospitals.

(l) Oklahoma: "Information not available."

(m) Texas: Year ending Aug. 31, 1947.

(n) Idaho: Biennium 1945-1947.

(o) Wyoming: 2 quarters ending September 30, 1947.

(p) Colorado: Does not include Denver Psychopathic Hospital.

(q) Washington: 3 quarters ending December 31, 1947.

DAILY PATIENT COSTS AT 246 STATE MENTAL HOSPITALS

Patient Cost per Day	POPULATION OF THE INDIVIDUAL HOSPITAL												Total Hospitals
	less than 500	500 —999	1000 —1499	1500 —1999	2000 —2499	2500 —2999	3000 —3499	3500 —3999	4000 —4499	4500 —4999	5000 —5999	over 6000	
Low	78¢	70¢	75¢	68¢	66¢	64¢	$1.12	82¢	94¢	$1.25	$1.13	93¢	
Median	$ 1.84	$1.42	$1.54	$1.17	$1.38	$1.47	$1.64	$1.42	$1.40	$1.33	$1.41	$1.54	
Average	$ 2.28	$1.52	$1.45	$1.26	$1.37	$1.45	$1.72	$1.37	$1.35	$1.46	$1.41	$1.45	
High	$16.47	$3.15	$2.33	$2.51	$2.57	$2.21	$2.34	$1.86	$1.63	$1.93	$1.53	$1.71	
$0.60 —0.69				2 Tenn. Tex.	2 Ky. Tex.	2 Tex.							6
$0.70 —0.79	1 W. Va.	2 Idaho Tenn.	1 Tex.	2 Ky.	2 Tenn. Tex.	2 N. Car. Tex.							10
$0.80 —0.89	1 W. Va.	1 W. Va.	2 Minn. Ind.	6 Iowa Kan. Neb. W. Va. Tenn. Ind.	1 Ind.			2 Miss. Va.					13
$0.90 —0.99	1 Tex.		3 Minn. (2) Ore.	3 Iowa (2) Kan.	2 Va. Ind.	1 Ohio			1 La.			1 Ga.	12
$1.00 —1.09		4 Ky. Ohio S. Car. W. Va.	3 Minn. Ind. (2)	7 Iowa (2) Minn. (2) S. Dak. Va. Ind.	1 La.								15
$1.10 —1.19	1 Penn.	4 Minn. N. Car. Wyo. Ind.	4 Neb. Ohio Va. Vt.	5 Kan. N. J. Md. Mo. (2)	3 Minn. (2) Ohio	2 Ohio Ore.	1 Penn.		1 Penn.		2 Ala.		23
$1.20 —1.29	2 Idaho Penn.	1 Idaho		3 Iowa Ohio Va.	2 Md. Penn.	4 Md. Ohio Penn. R. I.			1 Calif.	3 Ark. Ill. S. Car.	1 Fla.	1 Penn.	18

A Budget Survey of

$1.30 — 1.39	2 Del. Colo.	1 Wis.	1 Neb.	3 Mass. Mont. Penn.	3 Penn. (2) Wash.	3 Calif. Ohio (2)		1 Calif.	2 Calif. N. Y.	1 Calif.			17
$1.40 — 1.49		4 La. Penn. N. J. N. M.	2 Md. Utah	4 Me. Mass. Ohio Wis.	4 Mass. Ohio Penn. Wash.	2 N. Car. Penn.	1 Calif.	1 N. Y.	4 Calif. Ill. Mich. N. Y.		2 Ill. N. J.		24
$1.50 — 1.59	3 Md. Nev. Va.	1 Penn.	3 Me. (2) Penn.	2 Mass. Neb.	1 Mass.	4 Calif. Mass.(2) N. Y.	3 Mich. (2) Penn.			1 Ill.	1 N. Y.	2 Ill. N. Y.	21
$1.60 — 1.69		1 Mont.	6 Ariz. Mass.(2) Ohio Penn. Wash.	5 Calif. Mass. (3) Ohio	2 Mo.	2 N. J. Wash.	1 Conn.		1 N. Y.			1 N. Y.	19
$1.70 — 1.79	1 Colo.	3 N. Car. N. J. Wash.	3 Del. Mass. Mich.	1 Mass.	4 Conn. Ill. Mich. Penn.	1 N. Y.	2 Ill. N. Y.			1 Colo.		2 N. Y.	18
$1.80 — 1.89	1 Penn.	1 N. J.	1 Mass.	2 Ill. Mich.	2 Ill. N. Car.	3 Conn. Mich. Mo.		2 Ill. N. Y.					12
$1.90 — 1.99		2 Mich. Penn.	2 Mich. Penn.		2 N. H. N. Y.	3 Ill. N. Y. (2)	1 N. Y.			1 N. Y.			11
$2.00 and over	12 Ohio $2.22 Mich 2.22 Ill. 2.30 Minn 2.42 Wis. 2.71 Fla. 2.97 Ohio 4.31 Ohio 7.14 Ohio 7.49 Ohio 8.57 N.Y. 9.58 N.Y. 16.47	5 Wis. $2.01 Ky. 2.29 Wis. 2.41 N.Y. 2.47 Cal. 3.15	3 Conn $2.13 Mich 2.14 Conn 2.33	2 N.Y. $2.43 Ohio 2.51	1 N.Y. $2.57	2 N.Y. $2.13 N.Y. 2.21	2 N.J. $2.14 N.Y. 2.34						27
Total Hospitals	25	30	34	47	32	31	11	6	10	7	6	7	246

Note: Daily patient costs were reported for 246 out of 261 hospitals. No figures were available from North Dakota and Oklahoma. Cost figures were received for only two Alabama hospitals and only one Mississippi hospital. Costs are based on the latest information in each state at the time of the Survey. See table "WHAT WERE YOUR PER CAPITA COSTS FOR MAINTENANCE IN YOUR LATEST FISCAL YEAR" for the fiscal period used by each state.

Question: HOW ARE COMMODITIES FOR YOUR MENTAL HOSPITALS PURCHASED?

STATE	Central State Purchasing Agent	Department Purchasing Agent	Each Individual Institution	Both Central State Purchasing Agent and Institution	NOTES AND COMMENT
NEW ENGLAND					
Maine	..	..	..	X	
New Hampshire	X	..	..	..	
Vermont	X	..	..	..	
Massachusetts	..	..	..	X	
Rhode Island	X	..	..	..	
Connecticut	X	..	..	..	
MIDDLE ATLANTIC					
New York	..	..	..	(a)	
New Jersey	..	..	..	(b)	
Pennsylvania	..	..	..	(c)	
EAST NORTH CENTRAL					
Ohio	..	..	..	(d)	
Indiana	X	..	..	..	
Illinois	..	..	..	X	
Michigan	..	..	..	X	
Wisconsin	..	..	..	X	
WEST NORTH CENTRAL					
Minnesota	X	..	..	..	
Iowa	..	X	..	..	
Missouri	..	..	..	(e)	
North Dakota	..	..	..	(f)	
South Dakota	X	..	..	..	
Nebraska	..	..	..	X	
Kansas	..	..	..	X	
SOUTH ATLANTIC					
Delaware	..	..	X	..	
Maryland	X	..	..	..	
Virginia	..	..	..	X	
West Virginia	..	..	..	X	
North Carolina	..	..	..	(g)	
South Carolina	..	(h)	..	..	
Georgia	..	..	..	X	
Florida	..	(i)	..	..	
EAST SOUTH CENTRAL					
Kentucky	X	..	..	..	
Tennessee	X	..	..	..	
Alabama	..	..	(j)	..	
Mississippi	..	..	..	(k)	
WEST SOUTH CENTRAL					
Arkansas	X	..	..	..	
Louisiana	X	..	..	..	
Oklahoma	..	..	..	X	
Texas	..	..	..	X	
MOUNTAIN					
Montana	X	..	..	..	
Idaho	..	..	..	X	
Wyoming	..	..	..	X	
Colorado	..	..	..	X	
New Mexico	..	..	..	X	
Arizona	..	..	(l)	..	
Utah	X	..	..	..	
Nevada	..	..	X	..	
PACIFIC					
Washington	X	..	..	..	
Oregon	X	..	..	..	
California	X	..	..	..	
TOTAL	17	3	4	24	

(a) New York: "Requirement lists for commodities are submitted to the Division of Standards and Purchase in the Executive Department. This Division writes specifications, advertises for bids, and lets contracts for supplying the requirements. When contracts cannot be let, institutions are permitted to make open market purchases after obtaining three bids and approval of the proposed orders by the Division of Standards and Purchase. Bids are not required for open market purchases of less than $500.00."

(b) New Jersey: "But perishable food stuffs are under the direction of the Central State Purchasing Agent."

(c) Pennsylvania: "Each individual institution can purchase perishable and emergency items."

(d) Ohio: "Each individual institution can purchase for emergency up to $500.00."

(e) Missouri: "Under the direction of the Central State Purchasing Agent except for emergencies."

(f) North Dakota: "Small items are purchased by the institutions."

(g) North Carolina: "Contracts are awarded by Central State Agent; orders are placed by purchasing agent of each institution.

(h) South Carolina: "In addition to the Department Purchasing Agent, South Carolina Hospital purchases supplies."

(i) Florida: "Purchasing Agent is employed by the Board of Commissioners of State institutions."

(j) Alabama: "Practically all of the purchasing for our three institutions is done by the Steward."

(k) Mississippi: "We have one purchasing agent for our three mental institutions."

(l) Arizona: "All purchasing is done by the institution."

* For further information on the question, see COUNCIL OF STATE GOVERNMENTS publication BX-268 (May 9, 1947) "Purchasing by the States."

Question: WHAT PRICE LEVEL DO YOU USE IN ESTIMATING COMMODITY PRICES FOR BUDGET PURPOSES?

STATE	PRICE LEVEL					NOTES AND COMMENT
	Retail	Wholesale	Between Retail and Wholesale	Your Own Level	Cost Accounting Methods	
NEW ENGLAND						
Maine	..	X	..	..	..	
New Hampshire	..	..	..	..	X	
Vermont	..	..	..	..	X	
Massachusetts	..	..	..	X	..	
Rhode Island	..	X	..	..	..	
Connecticut	..	..	..	X	..	
MIDDLE ATLANTIC						
New York	..	X	..	..	..	
New Jersey	..	X	..	..	..	
Pennsylvania	..	..	..	X	..	
EAST NORTH CENTRAL						
Ohio	..	..	..	X	..	
Indiana	..	..	X	..	..	
Illinois	..	..	X	..	..	
Michigan §	..	(X)	..	(X)	..	
Wisconsin	..	X	..	..	..	
WEST NORTH CENTRAL						
Minnesota	..	..	..	X	..	
Iowa §	..	(X)	..	(X)	..	
Missouri §	..	(X)	..	(X)	..	
North Dakota	..	..	..	X	..	
South Dakota #						
Nebraska	..	..	..	X	..	
Kansas	..	..	X	..	..	
SOUTH ATLANTIC						
Delaware	..	X	..	..	..	
Maryland	..	..	..	X	..	
Virginia §	(X)	(X)	(X)	(X)	(X)	
West Virginia	..	..	..	..	X	
North Carolina	..	..	..	X	..	
South Carolina	..	..	..	X	..	
Georgia	..	X	..	..	..	
Florida §	..	..	..	(X)	(X)	
EAST SOUTH CENTRAL						
Kentucky	..	..	..	X	..	
Tennessee	..	..	X	..	..	
Alabama	..	X	..	..	..	
Mississippi	..	..	X	..	..	
WEST SOUTH CENTRAL						
Arkansas §	(a)	..	..	(X)	..	
Louisiana	..	..	..	..	X	
Oklahoma	..	..	..	X	..	
Texas	..	X	..	..	..	
MOUNTAIN						
Montana	..	X	..	..	..	
Idaho	..	..	..	X	..	
Wyoming	X	..	..	..	..	
Colorado §	..	(X)	..	(X)	..	
New Mexico	..	X	..	..	..	
Arizona	..	X	..	..	..	
Utah	..	X	..	..	..	
Nevada	..	X	..	..	..	
PACIFIC						
Washington	..	..	..	X	..	
Oregon	..	X	..	..	..	
California	..	..	..	(b)	..	
TOTAL § #	1	15	5	15	4	

8 states not in table total:
§ Combination of methods (7 states).
# No answer (1 state).

(a) Arkansas: "A retail price level is used for farm production only."

(b) California: "Soon after the call for budgets goes out, the Division of Budgets and Accounts, State Department of Finance, furnishes to state agencies a preliminary forecast of population and economic conditions in which the assumptions for budget purposes in regard to price trends are set forth in broad terms."

Question: AVERAGE PRICES PAID FOR CERTAIN ESSENTIAL FOODS DURING THE

STATE	DAIRY PRODUCTS				EGGS	FRUITS & VEGETABLES					STAPLES				
	butter (1b)	butterine (1b)	cottage cheese (1b)	milk (gal)	(doz)	oranges (case)	lettuce (case)	dried peaches (1b)	dried prunes (1b)	navy beans (1b)	coffee (1b)	flour (cwt)	rolled oats (1b)	soda crackers (1b)	sugar (cwt)
NEW ENGLAND															
Maine	67¢	31¢	-¢	70¢	60¢	$5.34	$ -	19¢	14¢	17¢	35¢	$6.58	8¢	16¢	$8.00
New Hampshire	72	27	34	60	56	5.38	5.96	21	20	14	29	5.39	8	24	8.54
Vermont	76	30	15	72	62	6.50	6.02	10	15	14	35	6.89	8	18	8.85
Massachusetts	68	27	-	-	58	-	-	23	18	13	28	5.78	7	18	8.40
Rhode Island	-	30	-	60	67	-	-	-	-	-	-	5.50	8	16	8.40
Connecticut	72	29	22	59	58	-	-	12	12	12	24	6.10	7	16	8.55
MIDDLE ATLANTIC															
New York	68	¶	11	54	59	5.04	6.30	-	14	15	23	5.90	7	18	8.78
New Jersey	71	26	-	-	60	3.69	-	11	11	-	25	5.70	7	18	8.30
Pennsylvania	70	¶	-	*	57	3.52	*	-	14	14	33	6.23	-	-	8.49
EAST NORTH CENTRAL															
Ohio	77	28	14	53	56	5.74	5.63	-	12	9	23	6.50	7	17	8.75
Indiana	69	35	-	40	60	4.50	-	-	14	-	32	5.00	8	17	8.70
Illinois	70	29	9	44	48	4.21	5.04	-	11	11	32	6.10	6	16	8.73
Michigan	71	22	8	47	54	†	†	15	12	13	31	6.27	6	17	8.84
Wisconsin	79	¶	-	-	48	-	-	16	15	11	27	6.12	6	18	8.82
WEST NORTH CENTRAL															
Minnesota	73	¶	17	53	42	6.69	5.75	14	13	11	27	6.59	7	18	9.17
Iowa	68	¶	12	46	40	5.98	5.88	15	13	12	32	5.84	7	16	9.00
Missouri #															
North Dakota	80	-	-	-	39	6.75	5.60	15	12	13	37	6.77	7	9	9.06
South Dakota #															
Nebraska	71	¶	15	50	-	5.00	5.65	13	12	12	23	5.45	7	16	8.96
Kansas	77	-	-	-	-	-	-	12	13	11	33	9.20	-	18	9.15
SOUTH ATLANTIC															
Delaware	68	35	14	67	62	6.51	7.75	-	16	14	32	7.90	9	20	8.85
Maryland	-	27	15	-	59	4.82	6.90	12	12	15	17	6.25	7	17	8.34
Virginia	76	29	-	36	-	5.29	5.56	13	12	14	28	6.10	11	17	9.80
West Virginia	71	32	-	-	-	5.75	7.60	15	15	13	39	6.65	7	10	8.81
North Carolina #															
South Carolina	73	29	-	42	47	5.75	4.76	14	13	11	29	5.69	-	23	8.59
Georgia	65	32	-	60	-	-	-	14	12	-	19	5.89	8	18	8.39
Florida	70	28	-	70	67	2.50	6.66	13	14	12	-	5.76	9	21	8.72
EAST SOUTH CENTRAL															
Kentucky #															
Tennessee	80	-	-	*	-	3.00	5.00	14	13	15	30	7.00	10	12	9.00
Alabama	-	27	-	-	50	3.50	-	12	12	12	19	6.00	9	18	8.75
Mississippi	-	35	-	80	47	3.75	3.75	10	-	12	21	6.00	10	23	8.50
WEST SOUTH CENTRAL															
Arkansas	70	31	-	45	49	5.04	5.08	13	14	-	22	6.38	10	16	8.63
Louisiana #															
Oklahoma	-	29	-	-	-	5.19	5.86	13	11	10	15	6.19	9	18	-
Texas	†	†	†	†	-	†	†	12	13	10	24	-	7	17	-
MOUNTAIN															
Montana	70	¶	-	68	70	6.50	4.50	15	11	12	35	7.00	8	-	10.00
Idaho #															
Wyoming	66	33	-	-	-	4.00	4.50	-	-	-	44	-	-	21	9.30
Colorado	73	24	10	51	55	3.50	6.50	16	14	14	32	5.88	9	17	9.98
New Mexico	*	¶	*	*	*	4.80	3.95	-	-	15	44	5.71	8	22	9.50
Arizona	-	35	-	35	-	-	8.40	-	-	15	36	6.40	11	16	9.00
Utah	81	-	-	-	63	5.00	-	-	-	-	30	5.60	8	-	9.33
Nevada	*	*	*	*	*	-	-	-	-	-	34	7.50	8	-	9.04
PACIFIC															
Washington	75	-	15	55	68	5.00	5.85	18	14	12	37	6.76	8	15	8.89
Oregon #															
California	70	32	18	56	55	4.18	-	13	10	14	29	6.42	6	17	8.40
low price	65	22	8	35	39	2.50	3.75	10	10	9	15	5.00	6	9	8.00
median price	71	29	15	54	57	5.00	5.75	13	13	13	30	6.12	8	17	8.81
high price	81	35	34	80	70	6.75	8.40	23	20	17	44	9.20	11	24	10.00

QUARTER JULY 1 TO SEPTEMBER 30, 1947.

MEATS					STATE	NOTES AND COMMENT
frank-furters (1b)	ham (1b)	pork sausage (1b)	all beef varieties (1b)	cuts particularly important in the usual diet		
29¢	55¢	42¢	35¢	mutton 14¢	NEW ENGLAND	# No answer (7 states).
35	44	34	31		Maine	* Produced on hospital farm.
38	62	48	46	heifers 35¢	New Hampshire	† Bought by institution.
34	52	41	42	beef boneless chuck 48¢; fores 35¢	Vermont	¶ Use of butterine prohibited by state laws (8 states).
33	-	-	34	lamb 36¢; smoked shoulders 37¢; fowl 35¢	Massachusetts	
35	63	38	-	cow 32¢; steer 37¢	Rhode Island	
					Connecticut	
34	57	36	45		MIDDLE ATLANTIC	
38	57	-	48		New York	
-	-	-	45		New Jersey	Massachusetts: Dried fruits were bought on annual contracts dated Nov. 1, 1946; staple goods were bought on 6-months contracts dated May 1, 1947.
					Pennsylvania	
35	57	32	-	beef carcass 28¢	EAST NORTH CENTRAL	
38	73	40	38		Ohio	
30	58	29	42		Indiana	
36	60	40	28		Illinois	New York: Most beef purchases consist of full carcass. Coffee price refers to green coffee. The State has two roasting plants where coffee is roasted at approximate cost of $.07 per lb.
44	68	48	-	cows 34¢; steers 22¢*; cows 25¢*	Michigan	
					Wisconsin	
31	66	37	27	carcass 27¢; hindquarters 30¢; forequarters 26¢	WEST NORTH CENTRAL	
24	58	38	34	beef carcass 31¢	Minnesota	
					Iowa	Wisconsin: Milk, blended for dairy products, is $2.44 per cwt. Fresh fruits and vegetables are bought locally.
37	57	-	-	beef carcass 34¢	Missouri #	
					North Dakota	
30	*	*	30	liver 41¢; veal 37¢	South Dakota #	
30	52	37	35	carcass 30¢	Nebraska	Minnesota: Many institutions buy dairy, fruit, and vegetable products locally. Others produce their own.
					Kansas	
38	68	-	-	steers on hoof 25¢	SOUTH ATLANTIC	
23	56	27	-	beef, commercial grade 31¢	Delaware	
28	58	33	34		Maryland	Iowa: Most of the July-September 1947 prices were covered by 3-month contracts beginning July 1. Butter price is based on market prevailing at time of shipment as shown on U. S. Dept. of Agriculture Daily Market Report. Our contract varies from flat Chicago price on day of shipment to 2.5¢ above Chicago price.
39	63	36	23		Virginia	
					West Virginia	
27	62	-	-	cattle 39¢*	North Carolina #	
-	-	-	25		South Carolina	
-	48	-	-	beef carcass 26¢	Georgia	
					Florida	
					EAST SOUTH CENTRAL	
35	-	40	-	roast stew 40¢	Kentucky #	
30	55	43	25		Tennessee	Nebraska: Dried Fruits, staple goods, and meats are purchased quarterly on bids. We process our own pork products. Milk is bought for one institution only.
28	42	32	34		Alabama	
					Mississippi	
23	55	-	33		WEST SOUTH CENTRAL	
					Arkansas	
32	62	61	31	beef carcass 27¢; beef chuck 35¢	Louisiana #	South Carolina: We produce our own beef and milk requirements.
-	-	-	-		Oklahoma	
					Texas	Florida: No coffee was bought this quarter, due to previous large purchase of surplus property.
					MOUNTAIN	
42	62	48	29	liver 34¢	Montana	
					Idaho #	Texas: All beef, pork, flour and sugar bought on open market as requisitioned. Dairy products and vegetables bought locally.
35	-	-	-		Wyoming	
23	52	49	-	full carcass B Grade 28¢; A Grade 34¢	Colorado	
-	*	*	-	beef purchased, live weight 15¢	New Mexico	New Mexico: Dairy products, eggs, and pork furnished by hospital farm.
33	-	-	29		Arizona	
-	-	-	24		Utah	
-	-	-	-	beef live weight 14¢	Nevada	
					PACIFIC	Nevada: Dairy products all produced on our own farm. Approximately 1/3 of meat served is pork raised on our own farm.
34	62	46	30	mutton 15¢; fresh pork 44¢	Washington	
28	-	-	27		Oregon #	
					California	
23	42	27	23		low price	
33	58	39	33		median price	
44	73	61	48		high price	

Question: HOW DO YOU PRICE THE PRODUCTS FROM INSTITUTIONAL FARMS?

STATE	Not Priced	PRICE LEVEL: Retail	Wholesale	Between Retail and Wholesale	Your Own Level	Cost Accounting Methods
NEW ENGLAND						
Maine	..	..	X	..	..	..
New Hampshire	..	..	(a)	..	..	..
Vermont	..	..	..	..	X	..
Massachusetts	..	..	..	..	..	X
Rhode Island	..	..	X	..	..	..
Connecticut §	..	..	(b)	..	..	(X)
MIDDLE ATLANTIC						
New York	..	..	(c)	..	..	..
New Jersey	..	..	X	..	..	..
Pennsylvania	(d)	..	..	..	..	..
EAST NORTH CENTRAL						
Ohio	..	..	X	..	..	..
Indiana	..	..	..	X	..	..
Illinois §	..	..	(X)	..	(X)	..
Michigan	..	..	..	..	(e)	..
Wisconsin	..	..	X	..	..	..
WEST NORTH CENTRAL						
Minnesota	..	..	..	X	..	..
Iowa	..	..	X	..	..	..
Missouri	..	..	X	..	..	..
North Dakota	X	..	..	..	..	..
South Dakota	X	..	..	..	..	..
Nebraska	..	..	..	..	X	..
Kansas	..	..	X	..	..	..
SOUTH ATLANTIC						
Delaware	..	..	X	..	..	..
Maryland	..	..	X	..	..	..
Virginia	..	..	..	..	..	(f)
West Virginia	..	..	..	X	..	..
North Carolina	..	..	..	..	X	..
South Carolina	..	..	X	..	..	..
Georgia	..	..	X	..	..	..
Florida §	..	..	..	..	(X)	(X)
EAST SOUTH CENTRAL						
Kentucky	..	..	X	..	..	..
Tennessee	X	..	..	..	..	..
Alabama	..	..	(g)	..	..	..
Mississippi	..	..	..	..	X	..
WEST SOUTH CENTRAL						
Arkansas	..	X	..	..	..	..
Louisiana	X	..	..	..	..	..
Oklahoma	..	..	..	..	X	..
Texas	..	..	X	..	..	..
MOUNTAIN						
Montana §	..	..	(X)	..	(X)	..
Idaho	X	..	..	..	..	..
Wyoming #						
Colorado	..	..	..	..	X	..
New Mexico	..	..	X	..	..	..
Arizona	..	..	X	..	..	..
Utah #						
Nevada	..	..	X	..	..	..
PACIFIC						
Washington	..	..	..	..	X	..
Oregon	..	..	X	..	..	..
California	..	..	..	..	X	..
TOTAL § #	6	1	21	3	9	2

NOTES AND COMMENT

6 states not in table total:
§ Combination of methods (4 states).
# No answer (2 states).

(a) New Hampshire: "Prices are from The Weekly Farm Bulletin issued by the State Board of Agriculture."

(b) Connecticut: "Farm products are priced for cost accounting purposes. Surplus commodities are priced for budget control purposes but their value is not included in per capita costs."

(c) New York: "A committee (representing the Division of Standards and Purchase, the Division of the Budget, and the Departments operating farms) fixes farm prices monthly. Prices on products such as milk and pork are priced at very near the current wholesale price. Garden crops are priced far enough below market to compensate for their being run of the field and not graded."

(d) Pennsylvania: "Not priced. Home produced foods are charged to Dietary as they are delivered."

(e) Michigan: "Prices on products of institutional farms and surplus commodities are based on wholesale prices at time of usage. These prices are determined by the Agriculture Department in cooperation with the buyer of food and agricultural products. On all farm items, a price list is sent to the institutions at the beginning of the month. Institutions are allowed to buy some perishable items or emergencies under purchasing rules."

(f) Virginia: "Prices are set by cost accounting methods, also by state budget authorities."

(g) Alabama: "We price all farm produce raised on our farm, but this cost is not taken into consideration in our financial reports."

Question: HOW DO YOU PRICE SURPLUS COMMODITIES?

STATE	Not Priced	PRICE LEVEL					NOTES AND COMMENT
		Retail	Wholesale	Between Retail and Wholesale	Your Own Level	Cost Accounting Methods	
NEW ENGLAND							
Maine #							
New Hampshire #							
Vermont	..	..	..	..	X	..	
Massachusetts	..	..	..	..	..	X	
Rhode Island	X	..	..	..	..	..	
Connecticut	..	..	X	..	..	..	
MIDDLE ATLANTIC							
New York #							
New Jersey	X	..	..	..	..	..	
Pennsylvania	X	..	..	..	..	..	
EAST NORTH CENTRAL							
Ohio	..	..	X	..	..	..	
Indiana #							
Illinois	..	..	..	X	..	..	13 states not in table total:
Michigan	..	..	..	..	X	..	§ Combination of methods (1 state).
Wisconsin	X	..	..	..	..	..	# Noanswer (12 states).
WEST NORTH CENTRAL							
Minnesota	X	..	..	..	..	..	
Iowa	(a)	..	..	..	..	..	(a) Iowa: "The cost of handling is included in per capita costs."
Missouri	..	..	..	..	X	..	
North Dakota	X	..	..	..	..	..	
South Dakota #							(b) North Carolina: "The cost of handling is included in per capita costs."
Nebraska	..	..	..	..	X	..	
Kansas #							
SOUTH ATLANTIC							
Delaware	..	..	X	..	..	..	
Maryland	..	..	..	..	X	..	
Virginia	X	..	..	..	..	..	
West Virginia #							
North Carolina	(b)	..	..	..	..	..	
South Carolina	..	..	X	..	..	..	
Georgia	..	..	X	..	..	..	
Florida	..	..	..	..	..	X	
EAST SOUTH CENTRAL							
Kentucky	X	..	..	..	..	..	
Tennessee	X	..	..	..	..	..	
Alabama #							
Mississippi	..	..	X	..	..	..	
WEST SOUTH CENTRAL							
Arkansas	..	X	..	..	..	..	
Louisiana	X	..	..	..	..	..	
Oklahoma	..	..	..	..	X	..	
Texas	..	..	X	..	..	..	
MOUNTAIN							
Montana §	..	..	(X)	..	(X)	..	
Idaho	X	..	..	..	..	..	
Wyoming #							
Colorado #							
New Mexico	..	..	X	..	..	..	
Arizona	X	..	..	..	..	..	
Utah #							
Nevada	X	..	..	..	..	..	
PACIFIC							
Washington	X	..	..	..	..	..	
Oregon #							
California	..	..	..	..	X	..	
TOTAL § #	16	1	8	1	7	2	

Question: DO YOU PROJECT COMMODITY COSTS FROM A PARTICULAR BASE

STATE	Estimates are based on a particular				Latest Base Period For Commodity Cost Estimates
	Month	Quarter	Year	Other Period (Specify)	
BIENNIAL BUDGETS (July 1, 1947 — June 30, 1949)					
1. Arizona	..	..	X	..	July 1, 1945 - June 30, 1946
2. Arkansas	..	..	X	..	July 1, 1945 - June 30, 1946
3. Colorado	..	..	..	Biennium	July 1, 1945 - June 30, 1947
4. Connecticut	X	..	..	..	September 1946
5. Delaware	..	..	X	..	July 1, 1945 - June 30, 1946
6. Florida	..	X	..	..	July 1 - September 30, 1946
7. Georgia	..	X	..	..	Budgets prepared quarterly
8. Idaho	..	..	X	..	July 1, 1945 - June 30, 1946
9. Illinois	..	X	..	..	Oct. 1 - December 31, 1946
10. Indiana	..	..	X	..	Calendar Year 1946
11. Iowa	..	..	X	..	July 1, 1945 - June 30, 1946
12. Kansas	..	..	X	..	July 1, 1945 - June 30, 1946
13. Kentucky	..	..	..	Biennium	July 1, 1945 - June 30, 1947
14. Maine	..	..	X	..	July 1, 1945 - June 30, 1946
15. Maryland	..	X	..	..	July 1 - September 30, 1946
16. Minnesota §	..	(X)	..	(1940-41)	(see note)
17. Montana #					
18. Nebraska	..	X	..	..	Oct. 1 - December 31, 1946
19. New Hampshire	..	..	X	..	July 1, 1945 - June 30, 1946
20. New Mexico	..	X	..	..	Oct. 1 - December 31, 1946
21. North Carolina	..	..	X	..	July 1, 1945 - June 30, 1946
22. North Dakota	..	..	X	..	July 1, 1945 - June 30, 1946
23. Oklahoma	..	X	..	..	April 1, - June 30, 1946
24. Oregon	..	..	..	Biennium	July 1, 1945 - June 30, 1947
25. South Dakota	..	..	X	..	July 1, 1945 - June 30, 1946
26. Tennessee	..	..	X	..	July 1, 1945 - June 30, 1946
27. Utah #					
28. Nevada	..	X	..	..	Oct. 1 - December 31, 1946
29. Vermont #					
30. West Virginia	..	..	X	..	July 1, 1945 - June 30, 1946
31. Wisconsin	..	..	..	1939-40	U.S.Dept.of Labor Index 130.0
OTHER BIENNIAL BUDGETS					
1. Alabama	..	..	X	..	Oct. 1, 1946 - Sept. 30, 1947
2. Louisiana	..	..	..	6 months	Most recent six month period
3. Mississippi	..	..	X	..	Preceding fiscal year
4. Ohio	..	..	..	two months	November and December 1946
5. Pennsylvania	..	X	..	..	Dec. 1, 1946 - Feb. 28, 1947
6. Texas #					
7. Virginia	..	..	X	..	July 1, 1946 - June 30, 1947
8. Washington	..	..	..	Biennium	April 1, 1945 - March 31, 1947
9. Wyoming	..	..	..	Biennium	April 1, 1945 - March 31, 1947
ANNUAL BUDGETS					
1. California	X	..	..	..	(see note)
2. Massachusetts	..	X	..	..	July 1 - September 30, 1947
3. Michigan §	(X)	..	..	(6 months)	(see note)
4. Missouri	..	..	X	..	(see note)
5. New Jersey	..	..	..	Indefinite	Past experience
6. New York §	(X)	..	(X)	..	(see note)
7. Rhode Island	X	..	..	..	November 1946
8. South Carolina	..	..	X	..	Preceding fiscal year
Total § #	3	10	19	9	

PERIOD? IF SO, WHAT IS YOUR LATEST BASE PERIOD?

NOTES AND COMMENT

7 states not in table total:

§ Combination of methods (3 states).

No answer (4 states).

SUMMARY

Five states based cost estimates on experience during an entire biennium.

Most of the states based their estimates on experience during the fiscal year preceding the legislative session.

One state (Wisconsin) based cost estimates by referring back to the period (1939-40) and adjusting by use of BLS index.

One state (Minnesota) used a current price level but based its estimates on a percentage mark up from actual expenses and comparable quantities for items bought in 1940-41.

Two states (Michigan, New York) used a 6-month period on food and a one-month period on other commodities.

Two states (California and Rhode Island) established a food budget formula to determine the cash food requirement for institutions. The cost of the ration (3 meals) was determined by applying prices prevailing during a particular month to the quantities of foodstuffs listed in the ration.

The 31 states which have the same biennial fiscal period (July 1, 1947 to June 30, 1949) based their estimates on the following periods:

	Number of States
Fiscal year ending June 30, 1946	14
Biennium ending June 30, 1947	3
Quarter (Oct. 1 to Dec. 31, 1946)	4
Quarter (July 1 to Sept. 30, 1946)	2
Quarter (April 1 to June 30, 1946)	1
Regular quarterly budgets	1
One month	1
Fiscal year 1939-40	1
Fiscal year 1940-41 and quarter	1
# No answer	3
Total	31

The comments from twenty states on this question are paraphrased as follows:

Alabama: We prepare a budget estimate for three years. This is prepared on the basis of our past experience, plus an estimated increase in patients, plus an estimated price increase. The last budget prepared was done January 30, 1947, for fiscal years ending 1947-1948-1949.

Our appropriation for the Alabama State Hospitals (Bryce and Searcy Hospitals) was prior to October 1, 1947, $7.50 per week per patient. After October 1, 1947 it is $10.00.

Arizona: Our budget was based on cost of food and percentage increase in institution population. The budget was estimated on percentage plan instead of dollar increase.

California: Budget provisions for commodities are projected from a significant base period, taking into account anticipated future economic conditions. For instance, operating expenses for "Feeding" shown in the Governor's printed budget submitted to the Legislature for the 1948-49 year are based upon the food ration priced at September, 1947 levels of State of California prices, as furnished by our State Purchasing Division. Base periods for other commodities and services are specifically indicated in the report of the Department of Mental Hygiene: "Tabulation of 1948-49 Budget Requests Together with Pertinent Information and Sundry Statistics as Presented to Legislative Committees."

We have found a rather close correlation between State price trends and the trends in the Bureau of Labor Statistics indexes. Soon after the call for budgets goes out, this department furnishes to State agencies a preliminary forecast of population and economic conditions, in which the assumptions for budget purposes in regard to price trends are set forth in broad terms. Due to developments occurring between October and December, when budgets were closed, it was necessary to modify certain of the earlier assumptions. The food price outlook in particular, became confused due to uncertainties as to the possible effect of the Marshall Plan and further wage increases. It was therefore determined to make no allowance in the detailed budgets for changes in food prices, but to provide, instead, a lump sum appropriation of $2,000,000 to be allocated by the Department of Finance should commodity prices (or institutional populations)

Question: DO YOU PROJECT COMMODITY COSTS FROM A PARTICULAR BASE

NOTES AND COMMENT

exceed the levels assumed in the budget.

Connecticut: In Connecticut, appropriations are based on prices as of September preceding the legislative session, thus eliminating any guessing as to future trends. For the maintenance of inmates at institutions, additions can be made to appropriations by the Governor and the Finance Advisory Committee, the majority group of which is made up of members of the legislative appropriations committee. This eliminates the possibility of any change in the treatment of patients as a result of bad guessing on future prices. It is expected that some substantial increases may be required during the current fiscal year.

Georgia: Our budgets are prepared and submitted quarterly—current prices used.

Idaho: We attempted to "beat inflation" by having institutions produce more of their own needs, expanding canning facilities, and plan quick-freeze systems; also interchange surplus canned goods produced by institutions. Our estimates for commodities were based on expenditures for 1945-46 plus a 30% increase.

Kansas: Our estimated costs in preparing the budget, are based on costs during the 1946 fiscal year and the subsequent three-month period. The Legislature in making appropriations, took into consideration appropriations and fee balances carried forward, new direct appropriations requested, and estimated future fee collections and expenditures.

Kentucky: Estimates were based on expenditures for the two previous fiscal years, increased prices being taken into account. The amount of the deficiency was arrived at by the simple expediency of deducting the balance of funds on hand plus the anticipated revenue from patients from the estimated minimum requirements for the remainder of the fiscal year. Personal Service, utilities, materials and supplies and fixed charges were included, of course, in the estimate of requirements, but we could not say that such a percentage of the deficiency was in the personal service classification and another percentage was in the materials and supplies. Our appropriations are made in lump sums for maintenance.

Louisiana: Our 1946-48 budget was based on the most recently completed six months period with consideration given to price trends and patient census expectancy.

Maryland: We gave greatly increased allowances to our mental disease hospitals for the current biennium, both in the number of personnel and in operating expenses. In fact, they were provided practically everything that they requested with the exception that only one-half of the additional employees requested were allowed in the first year of the biennium. This was done because it was thought that it would be impossible for the institutions to secure the total number of employees. This judgment has been borne out by the actual experience to date, the hospitals still operating with a large percentage of vacancies. In addition to the provisions made in the legislative budget, the salaries of the attendant group in the hospitals were again raised, effective July 1, 1947.

Food allowances were based on 45¢ per day for patients and authorized employees. This amount was based on the hospitals' actual cost for the quarter July 1 to September 30, 1946. The best advice we could obtain during the closing months of 1946 was that food prices would increase slightly during 1947 and decline during 1948. This, of course, has not happened. The food allowance was supposed to have covered improvement in the diet because of the fact that previous allowances had not been made for employees. In other words, the experience, based on 45¢ over-all cost for patients only, was for the total number of patients and employees. The allotments made have proved sufficient, including an improved diet, for the first six months of the fiscal year on a prorated basis. Patient population below the estimates and shortage of employees have helped to make this possible. The hospitals fear, however, that with the continued increase in costs, that one-half of the appropriation remaining for the second six months of the year will not be sufficient.

Michigan: The 1948-49 budget recommendations used average cost of food for July 1 to December 31, 1947. Other commodities were based on current costs as of December, 1947. In all our per capita cost figures, the average is computed as the total cost divided by number of patient days. Employee cost is reflected but no patient days are figured for employees. In projecting all other costs at current prices as of December 1947, we used a statement of monthly operating costs which breaks down operating costs into a great many items.

During previous years, appropriations have been made on a net basis. Net was determined for food by multiplying patient days by estimated daily per capita, and a deduction made of the estimated amount of farm production to be used as food. For the next year, 1948-49, appropriation will be made

PERIOD? IF SO, WHAT IS YOUR LATEST BASE PERIOD? *continued*

NOTES AND COMMENT

on a gross basis and all farm production credits will reflect in the general fund instead of being credited to individual institution accounts.

Minnesota: All of the institutions are financed by Legislative appropriations for Current Expense (provisions, supplies and operating expenses), Salaries (personal services of officers and employees), and Repairs (materials, supplies and labor for general repairs and maintenance of buildings and equipment). In addition, capital outlay is financed by special Legislative appropriations for specific items of equipment and improvements. A contingent fund (this biennium $150,000) is established to meet emergencies in Current Expense, Repairs, special construction, etc. Personnel, commodities and the resources with which to obtain them are utilized in the most efficient manner possible. Canning programs accelerated during the war to conserve and preserve food crops have been continued. All crops raised are used at the institution, or, in cases of surplus, transferred among other institutions to ease shortages.

For the 1947-49 biennium, the 1947 Legislature made available appropriations for current expense based on July-September 1946 price levels for commodities comparable in quantity to 1940-41 which was the last year of normal deliveries of merchandise.

Minnesota's 1947-49 estimates were a percentage cost mark-up from actual expenses for comparable quantities and items for 1940-41, based on July-September 1946 costs. (1) Clothing 142%; provisions 130%; miscellaneous materials 87%; forage 131% (of 1941-42 actual).

Salary appropriations were in accordance with the newly approved salary plan based on cost-of-living index. Appropriations for repairs allowed for increased costs and demand. Price increases over the July-September 1946 level and additional cost-of-living salary increases will result in some deficit over the two-year period.

To relieve overcrowded, inadequate and obsolete facilities, the state has launched on a building program, estimated to take five years to complete, in excess of 11 million dollars for state institutions.

Missouri: Our 1947-48 budget request was based on $1.25 per day per patient—1946 base period plus anticipated increase in cost plus deferred requirements. An increase of 20% on consumer goods has been requested for 1948-49.

New York: The budget allowances for fiscal year (April 1, 1947 to March 31, 1948) were based on price levels in December 1947 for all commodities except food, clothing, household and medical supplies and expense. For these commodities, the consumption for the period April 1, 1946 to October 31, 1947 was also taken into consideration due to shortages in many commodities. These are the only commodities for which appropriations are computed on a per capita basis.

Appropriations for Food, Clothing, Household and Medical supplies are computed on an annual per capita basis. Other commodities and expenses are appropriated for on the basis of past experience, prices and scope of program, all of which vary from one institution to another.

North Dakota: Our estimates for commodities were based on expenditures for 1945-46 plus an increase of 12 1/2 per cent.

Oregon: Estimates were based on expenditures for previous biennium plus estimated food costs.

Rhode Island: As to the problem of food: —In November 1946 the Supervising Dietitian of our institutions prepared a detailed technical analysis of a basic ration and cost for each of the institutions. The dietary cost was computed by extending the prices prevailing during the month against the specific quantities of food allowed. At that time no allowance was made for an increase in food prices above the base month. In September 1947 the same process was followed. This procedure of determining food costs is flexible in that it can be based on prices during any specified time.

South Carolina: All our costs are based upon a per capita cost. In our application for funds for fiscal year 1948-49, we based our cost upon the expenditures for 1947-48.

Tennessee: "In studying the requests for appropriation we determined the amounts to be received from reimbursements and based our increases on the Department of Labor food costs indexes. The last appropriations were increased on the basis of increased food costs at time of request. We are now finding that price increases are creating some strain on the work programs."

Virginia: An increase of about 50 per cent in the appropriation for the mental hospitals will be recommended for maintenance and operation in the executive budget for the biennium July 1, 1948 to June 30, 1950.

Question: DO YOU USE PRICE INDEXES IN ESTIMATING COMMODITY PRICES FOR BUDGET PURPOSES?

STATE	No	Bureau of Labor	Your Own	NOTES AND COMMENT
NEW ENGLAND				
Maine §	..	(X)	(X)	
New Hampshire	..	..	X	
Vermont	X	..	..	
Massachusetts	..	..	X	
Rhode Island	..	X	..	
Connecticut	..	..	X	
MIDDLE ATLANTIC				
New York	..	X	..	
New Jersey	(a)	..	..	
Pennsylvania	..	..	X	
EAST NORTH CENTRAL				
Ohio §	..	(b)	(X)	
Indiana	..	..	X	
Illinois §	..	(X)	(X)	
Michigan	..	X	..	
Wisconsin	..	X	..	
WEST NORTH CENTRAL				
Minnesota	..	..	(c)	
Iowa	..	..	X	
Missouri	..	..	X	
North Dakota #				
South Dakota	..	..	X	
Nebraska	..	X	..	
Kansas #				
SOUTH ATLANTIC				
Delaware §	..	(X)	(X)	
Maryland §	..	(d)	(X)	
Virginia	X	..	..	
West Virginia	..	X	..	
North Carolina	..	..	X	
South Carolina	..	..	X	
Georgia	..	..	(e)	
Florida	..	..	X	
EAST SOUTH CENTRAL				
Kentucky #				
Tennessee	..	X	..	
Alabama	X	..	..	
Mississippi	..	..	(f)	
WEST SOUTH CENTRAL				
Arkansas	..	..	X	
Louisiana	X	..	..	
Oklahoma	..	X	..	
Texas	X	..	..	
MOUNTAIN				
Montana	..	..	X	
Idaho	..	(g)	..	
Wyoming	X	..	..	
Colorado	..	..	X	
New Mexico	..	..	X	
Arizona	..	..	X	
Utah	..	..	X	
Nevada	..	..	X	
PACIFIC				
Washington	..	..	X	
Oregon	..	..	X	
California	..	(h)	..	
TOTAL § #	7	10	23	

8 states not in table total:
§ Combination of methods (5 states).
# No answer (3 states).

(a) New Jersey: "Not much attention is given to individual price indexes."

(b) Ohio: Additional information from the Department of Agriculture and Ohio State University used.

(c) Minnesota: "We use current wholesale prices."

(d) Maryland: Also the McGill Commodity Service Price Indexes, and the National Association of Purchasing Agents.

(e) Georgia: "We use current wholesale prices."

(f) Mississippi: "We use market evaluation."

(g) Idaho: The BLS index is used as a cross check.

(h) California: "We have found a rather close correlation between State price trends and the BLS indexes."

Question: DO YOU BASE YOUR FOOD COSTS ON A DIET SCHEDULE?

STATE	No	Your Own	U.S. Dept. of Agriculture	NOTES AND COMMENT
NEW ENGLAND				
Maine	X	..	..	6 states not in table total:
New Hampshire	..	X	..	# No answer (6 states).
Vermont	X	..	..	
Massachusetts	..	X	..	
Rhode Island	..	(a)	..	(a) Rhode Island: "In November 1946, the Supervising Dietitian of our institutions prepared a basic ration and its cost for each of the institutions. The Budget Committee recommended it and the Legislature appropriated the amount requested by the dietitian, adjusted slightly for estimates of population. At that time no allowance was made for an increase in food prices. In September 1947 the same process was followed, the dietitian preparing a similar analysis."
Connecticut	..	X	..	
MIDDLE ATLANTIC				
New York	..	X	..	
New Jersey	..	X	..	
Pennsylvania	..	X	..	
EAST NORTH CENTRAL				
Ohio	..	X	..	
Indiana	..	X	..	
Illinois	..	..	X	
Michigan	X	..	..	
Wisconsin	X	..	..	
WEST NORTH CENTRAL				
Minnesota	..	X	..	(b) Florida: "Food costs are based on actual accounting records."
Iowa	X	..	..	
Missouri #				
North Dakota	X	..	..	
South Dakota	X	..	..	
Nebraska	X	..	..	(c) Washington: "It is the aim of the Department to supply at all times a balanced diet taking into consideration the physical and mental condition of the patient and work assignments (if any)."
Kansas #				
SOUTH ATLANTIC				
Delaware	..	X	..	
Maryland	..	X	..	
Virginia	..	X	..	
West Virginia #				
North Carolina	X	..	..	(d) California: "Calculations of cost of feeding for budget purposes, are made on the gross basis, including the locally produced commodities, and a deduction taken for the estimated local production to be consumed. Sales of surplus commodities are credited to appropriation and to costs. Operating expenses for 'Feeding' shown in the Governor's printed budget submitted to the Legislature for the 1948-49 year were based upon a specific ration. The food ration was priced at September 1947 levels of State of California prices, as furnished by our State Purchasing Division. The estimates include the foodstuffs purchased for feeding or issuance to employees."
South Carolina	..	X	..	
Georgia	..	X	..	
Florida	..	(b)	..	
EAST SOUTH CENTRAL				
Kentucky	X	..	..	
Tennessee	..	X	..	
Alabama	..	X	..	
Mississippi	..	X	..	
WEST SOUTH CENTRAL				
Arkansas	..	X	..	
Louisiana	X	..	..	
Oklahoma	..	X	..	
Texas	X	..	..	
MOUNTAIN				
Montana #				
Idaho	X	..	..	
Wyoming #				
Colorado	..	X	..	
New Mexico	..	X	..	
Arizona	..	X	..	
Utah #				
Nevada	..	X	..	
PACIFIC				
Washington	..	(c)	..	
Oregon	..	X	..	
California	..	(d)	..	
TOTAL #	13	28	1	

Question: HOW DOES THE AMOUNT ANTICIPATED FOR COMMODITIES IN 1947-48 COMPARE WITH THE AMOUNT ALLOWED IN 1946-47?

STATE	Average Daily Resident Population (1946-47)	Amount for Commodities 1947-48	Increase for Commodities in 1947-48 over 1946-47 Amount	Percent	Period Covered is July 1, '47-June 30, '48 unless otherwise indicated
1. Alabama	6,834	$ ..	$ (a)	..	Oct. 1, '47-Sept. 30, '48
2. Arizona	1,255	135,000	(b)	..	
3. Arkansas	4,803	1,075,367	300,000	39%	
4. California	32,191	10,328,511	1,472,903 (c)	17	July 1, '48-June 30, '49
5. Colorado	5,400	1,643,310*	257,063	19	
6. Connecticut	10,590	2,719,415*	662,150 (d)	32	
7. Delaware	1,259	420,570*	65,574 (e)	18	
8. Florida	6,184	2,042,050*	774,530 (f)	61	
9. Georgia	8,895	1,825,000	291,406 (g)	19	
10. Idaho	1,704	316,031*	16,708 (h)	6	
11. Illinois	41,798	15,675,000*	5,406,446 (i)	53	
12. Indiana	12,827	2,138,619	262,000	14	
13. Iowa	10,022	1,891,950	312,450	20	
14. Kansas	5,075	792,000	173,400	28	
15. Kentucky	7,210	..	.. (j)	..	
16. Louisiana ‡	7,715				
17. Maine	3,777	1,025,407	61,668 (k)	6	
18. Maryland	8,517	2,733,270	1,066,514 (l)	64	
19. Massachusetts	27,992	8,224,000	2,450,000	42	
20. Michigan	21,770	6,629,790	893,638 (m)	16	July 1, '48-June 30, '49
21. Minnesota	14,339	1,990,332*	562,608 (n)	39	
22. Mississippi	4,792	..	.. (o)	..	see note (o)
23. Missouri	10,542	2,505,500	400,000 (p)	19	
24. Montana	2,326	..	.. (q)	..	
25. Nebraska	5,886	1,227,500*	312,500	34	
26. Nevada	327	..	.. (r)	..	
27. New Hampshire	2,406	831,693	214,467	35	
28. New Jersey	15,587	3,134,450	.. (s)	..	see note (s)
29. New Mexico ‡	963				
30. New York	92,679	30,611,459	6,627,323 (t)	28	Apr. 1, '47-Mar. 31, '48
31. North Carolina	8,909	2,207,322	293,159 (u)	..	see note (u)
32. North Dakota	3,060	..	.. (v)	..	
33. Ohio	29,768	8,677,220*	2,830,796 (w)	48	Jan. 1, '47-Dec. 31, '48
34. Oklahoma	8,978	2,790,000	600,000	27	
35. Oregon ‡	4,004				
36. Pennsylvania	42,174	8,500,000	1,500,000	21	June 1, '47-May 31, '48
37. Rhode Island	2,970	602,200	185,700	45	
38. South Carolina	4,842	..	.. (x)	..	
39. South Dakota	1,651	322,000	52,000	19	
40. Tennessee ‡	6,843		.. (y)	..	
41. Texas	16,858	3,862,075	989,900 (z)	34	Sept. 1, '47-Aug. 31, '48
42. Utah	1,149	440,000	115,000	35	
43. Vermont ‡	1,083				
44. Virginia	11,324	2,289,403	522,753	30	
45. Washington	8,858	2,220,283*	820,620	59	Apr. 1, '47-Mar. 31, '48
46. West Virginia	4,447	771,250*	178,750	30	
47. Wisconsin ‡	4,355				
48. Wyoming	583	166,725*	25,000	18	Apr. 1, '47-Mar. 31, '48

Question: WAS AN INCREASE IN COMMODITY COSTS FOR 1947 - 48 ANTICIPATED BECAUSE OF HIGHER PRICES? OTHER REASONS? WHAT ABOUT FOOD?

STATE	Commodity cost increase due to prices				Other reasons for anticipating an increase in commodity costs						Anticipated increase in the cost of food	
	Allowed for in estimate		Increase due to price		diet improvement			population				
	Yes	No	Amount	Percent	Yes	No	Amount	Yes	No	Amount	Amount	Percent of commodity increase
1. Alabama	X	..	$ (a)	..	..	..	$ ..	..	..	$ ..	$ ..	..
2. Arizona	X	..	#	..	X	..	#	..	..	#	(b)	..
3. Arkansas	X	..	300,000	39%	..	X	..	..	X	..	200,000	67%
4. California	..	X	(c)	..	X	..	857,205	..	..	(c)	1,273,320	86
5. Colorado	X	..	257,063*	19	..	X	..	..	..	#	152,711*	59
6. Connecticut	..	(d)	662,150*	32	..	X	..	..	..	#	496,552*	75
7. Delaware	X	..	--	20	X	..	#	..	..	#	--	20
8. Florida	X	..	533,530*	35	..	X	..	X	..	$ 241,000*	500,000*	65
9. Georgia	X	..	(g)	..	..	..	#	..	..	#	(g)	..
10. Idaho	X	..	(h)	..	..	..	..	..	..	..	(h)	..
11. Illinois	X	..	(i)	..	X	..	#	X	..	..	..	..
12. Indiana	X	..	262,000	14	..	X	..	..	..	#	#	..
13. Iowa	X	..	#	..	..	X	..	..	..	#	142,000	45
14. Kansas	X	..	#	..	..	..	#	..	..	#	#	..
15. Kentucky	X	..	(j)	..	..	..	#	..	..	#	#	..
16. Louisiana ‡												
17. Maine	X	..	#	..	..	..	#	..	..	#	89,462(k)	..
18. Maryland	X	..	#	..	X	..	#	X	..	#	816,286	77
19. Massachusetts	X	..	#	42	..	X	..	..	..	#	600,000	25
20. Michigan	X	..	893,638	16	..	..	#	..	..	#	411,208	46
21. Minnesota	X	..	see note	..	..	X	..	..	..	#	338,778*	60
22. Mississippi	X	..	see note	..	X	..	100,000	..	..	..	300,000	(o)
23. Missouri	X	..	see note	..	..	..	..	..	..	..	..	..
24. Montana	..	..	(q)	..	..	..	..	..	..	..	(q)	..
25. Nebraska	X	..	250,000*	26	X	..	62,500*	..	X	..	150,000*	48
26. Nevada	X	..	(r)	..	..	X	..	..	X	..	(r)	..
27. New Hampshire	X	..	214,467	35	..	X	..	..	..	#	145,475	68
28. New Jersey	..	(s)	(s)	..	..	..	..	..	..	..	..	..
29. New Mexico ‡												
30. New York	X	..	4,475,823	17	X	..	1,000,000	X	..	1,151,500	3,264,121	49
31. North Carolina	X	..	..	#	..	..	#	..	..	#	135,421	46
32. North Dakota	(v)	..	..	..	..	..	..	..	..	..	..	..
33. Ohio	X	..	(w)	..	X	..	(w)	X	..	(w)	1,730,228*	61
34. Oklahoma	X	..	600,000	27	..	X	..	..	..	#	236,555	39
35. Oregon ‡												
36. Pennsylvania	X	..	1,500,000	21	..	X	..	..	..	#	1,000,000	67
37. Rhode Island	..	X	..	..	X	..	155,000	..	..	#	155,000	84
38. South Carolina	X	..	(x)	..	..	..	..	..	..	..	..	..
39. South Dakota	X	..	29,273	10	..	..	#	..	..	#	#	..
40. Tennessee ‡												
41. Texas	X	..	(z)	..	..	..	#	..	..	#	#	..
42. Utah	X	..	#	..	..	..	#	..	..	#	20,000	17
43. Vermont ‡												
44. Virginia	X	..	#	..	..	..	#	..	..	#	(aa)	..
45. Washington	X	..	750,445*	51	X	..	70,175*	..	..	#	438,622*	53
46. West Virginia	X	..	#	..	..	..	#	..	..	#	#	..
47. Wisconsin ‡												
48. Wyoming	X	..	#	..	..	..	#	..	..	#	12,500*	50

Question: HOW DOES THE AMOUNT ANTICIPATED FOR COMMODITIES IN 1947-48

NOTES AND COMMENT

‡ No information on this question (6 states).

No answer to this part of the question.

* Commodity estimate as indicated in the table is one half of the total appropriation for the biennial period.

(a) Alabama: "Our appropriations for the two Alabama Hospitals (Bryce and Searcy) include all commodities and salaries and labor. Prior to Oct. 1, 1947 the appropriation was $7.50 per week per patient; after Oct. 1, 1947 it is $10.00."

(b) Arizona: "Commodities are appropriated in a lump sum; no separation as to food."

(c) California: "Commodities, as reported, include contractual services, the amount of which is minor, except for natural gas for heating and cooking purposes.

"The figures include foodstuffs to be purchased for feeding or issuance to employees, amounting to $959,872 for 1948-49. In addition to the budget appropriation, it is estimated that locally produced food, valued at state prices, will amount to $2,292,938 for 1948-49.

"It is difficult for us to compute the overall amount allowed for commodity price increases, since such computations would require the isolation of that factor from all the other factors taken into account in the allowances.

"It should be pointed out that a large factor of increase over past years (not applicable, however, in comparing 1947-48 and 1948-49 expenditures) results from the depressed levels of expenditure during the war and immediate post war periods when many commodities were in short supply. The current and ensuing years' expenditure programs are based on the assumption that all authorized commodities can be obtained.

"Due to developments regarding economic conditions occurring between October and December, when budgets were closed, it was necessary to modify certain of the earlier assumptions regarding food costs. The food price outlook became confused due to uncertainties as to the possible effect of the Marshall Plan and further wage increases. It was therefore determined to make no allowance in the detailed budget for changes in food prices, but to provide, instead a lump sum appropriation of $2,000,000 to be allocated by the Department of Finance should commodity prices (or institutional populations) exceed the levels assumed in the budget."

(d) Connecticut: "Appropriations are based on prices as of September preceding the legislative session. No increase for prices was allowed above this base month."

(e) Delaware: Delaware State Hospital's estimate.

(f) Florida: Figure represents one half of the amount appropriated from General Revenue by the 1947 Legislature, for Necessary and Regular Expenses (excluding salaries) for the biennium July 1, 1947 to June 30, 1949. "We have not included Incidental Funds making up receipts from paying patients and other sales and services which are also appropriated as available for expenditure for such purposes as our Board of Commissioners of State Institutions may direct. We have estimated such income at $150,000 per year and requested that of this amount $50,000 per year be held available to supplement appropriation for Necessary and Regular Expenses and that $100,000 per year be held available to supplement appropriation for salaries."

(g) Georgia: "We do not have separate appropriations for commodities."

(h) Idaho: "Appropriations are made in one lump sum—no separation as to commodities or food supplies."

(i) Illinois: "This figure is one half of total estimated needs for the 1947-49 biennium."

(j) Kentucky: "Appropriation is made in lump sum—no breakdown as to commodities. This Legislature will be requested to appropriate a deficiency of approximately $500,000."

(k) Maine: "The increase in food costs over total commodity costs is due to a reduction in "Other Commodity" expenditures. Because the Legislature appropriates monies in a lump sum for each function, the figures were taken from actual expenditures for the first eight months of the fiscal year ending June 30, 1948. The last four months were taken from budget requests and would necessarily be on an estimated basis."

(l) Maryland: "We gave greatly increased allowances to our mental disease hospitals for the current biennium, both in the number of personnel

COMPARE WITH THE AMOUNT ALLOWED IN 1946-47? *continued*

NOTES AND COMMENT

and in operating expenses."

(m) Michigan: "This is the estimated increase for 1948-49 over the estimate for 1947-48."

(n) Minnesota: "Minnesota's estimates for the biennium 1947-49 were a percentage cost mark-up from actual expenses for comparable quantities and items for 1940-41, based on July-Sept. 1946 costs. They were as follows: clothing 142%; provisions 130%; miscellaneous materials 87%; forage 131% (of 1941-42 actual)."

(o) Mississippi: "For Mississippi State Hospital the 1948-50 Budget is $2,954,000, an increase of $983,000 above the 1946-48 Budget. An additional $530,000 is set up for capital items.

"The 1948-50 budget allows an increase of $300,000 for food. Also an increase of $100,000 is granted for diet improvement. The total covered an increase of $250,000 for prices."

(p) Missouri: "On consumer goods only the 1948-49 budget request was an increase of 20% above 1947-48."

(q) Montana: "Appropriation is made in one lump sum and provides for salaries and all other expenses."

(r) Nevada: "Appropriation is made in lump sum—no breakdown as to commodities."

(s) New Jersey: "The 1947-48 deficiency anticipated for food is $432,000."

(t) New York: "The estimate for commodities, in addition to current appropriation, includes deficiency appropriations of some $5,000,000 to complete the fiscal year ending March 31, 1948. Of these deficiencies, about $3,480,000 is estimated for food. Included in the figures given are $5,000,000 for deficiencies and $2,181,000 estimated farm production."

(u) North Carolina: "Farm products are priced only for the purpose of determining profits and losses on farming operations. These figures are for supplies and material purchases only and do not include estimates for farm produce. Actual for 1947-48 will increase about 25% for goods purchased. Home produce will increase in value likewise but not much in quantity. Same for surplus commodities."

(v) North Dakota: "Our appropriation of $2,754,200 was for total maintenance. We allowed approximately 12% increase for prices."

(w) Ohio: "Increases in appropriation shown include price increases, diet improvement and increased population but cannot be broken down separately for each item."

(x) South Carolina: "At South Carolina State Hospital we based our costs for 1948-49 upon the expenditures for 1947-48. All our costs are based upon a per capita cost. In the year 1946-47 the per capita cost was $1.2748; in 1947-48, we estimate it to be $1.345."

(y) Tennessee: "In studying the requests for appropriations we determined the amounts to be received from reimbursements and based our increases on Department of Labor Food Cost Indexes."

(z) Texas: "The Legislature has given the State Board of Control authority to transfer funds from one institution to another whenever necessary. This authority is so broad that in effect it amounts to a lump sum appropriation to the Board for the support of all institutions. In the past all unexpended balances have been reappropriated to the Board at the end of each fiscal year to be used as the Board saw fit during the following year. However, the unexpended balances at August 31, 1947, were not reappropriated. Consequently, the figures are misleading as we do not have the unexpended balances available although we do have an apparent increase in appropriations."

(aa) Virginia: "The 1947-48 budget estimate for food was $241,134 (14%) below food expenditures for 1946-47."

Question: WHAT DO YOU ESTIMATE FOR FOOD OUT OF YOUR CURRENT APPROPRIATION FOR COMMODITIES?

STATE	Amount	Percent of commodity total	Do you compute a per patient food cost per day? Yes	No	NOTES AND COMMENT
NEW ENGLAND					
Maine	$ 738,852	72%	X	..	
New Hampshire	526,000	63	X	..	
Vermont ‡			X	..	
Massachusetts	4,000,000	49	X	..	
Rhode Island	430,000	71	X	..	‡ No information on amount estimated for food (14 states)
Connecticut	1,425,400	52	X	..	
MIDDLE ATLANTIC					
New York	17,986,921 (a)	59	X	..	(a) New York: "This estimate for fiscal year ending March 31, 1948 includes farm production and deficiency appropriations."
New Jersey	1,702,000 (b)	54	X	..	
Pennsylvania	5,500,000	65	X	..	
EAST NORTH CENTRAL					
Ohio	4,128,000 (c)	48	X	..	(b) New Jersey: Regular appropriation plus estimated deficiency for fiscal year ending June 30, 1948.
Indiana	901,925	42	X	..	
Illinois	9,405,000 (d)	60	..	X	
Michigan	3,188,770 (e)	48	X	..	
Wisconsin ‡			..	X	(c) Ohio: Estimate for calendar year ending December 31, 1948.
WEST NORTH CENTRAL					
Minnesota	972,978	49	..	X	
Iowa	940,000	50	X	..	(d) Illinois: Estimate for fiscal year ending June 30, 1948.
Missouri	1,503,300	60	..	X	
North Dakota ‡			..	X	
South Dakota	90,160	28	..	X	(e) Michigan: Estimate for fiscal year ending June 30, 1949.
Nebraska	795,000	65	X	..	
Kansas	368,598	47	..	X	
SOUTH ATLANTIC					(f) Delaware: For Delaware State Hospital.
Delaware	212,686 (f)	51	..	X	
Maryland	1,595,560	58	X	..	(g) California: Estimate for fiscal year ending June 30, 1949.
Virginia	1,237,163	54	X	..	
West Virginia	475,000	62	..	X	
North Carolina	1,158,000	53	X	..	
South Carolina ‡			X	..	Note: The percentages in the second column were not reported as such by the states but were calculated from the amounts reported for food and for total commodities. A few states reporting only one of these figures are included in the group of states with no information on the subject.
Georgia ‡			X	..	
Florida	1,125,000	55	X	..	
EAST SOUTH CENTRAL					
Kentucky ‡			X	..	
Tennessee	735,530	61	X	..	
Alabama ‡			X	..	
Mississippi ‡			X	..	
WEST SOUTH CENTRAL					See table Page 50
Arkansas	600,000	56	X	..	
Louisiana ‡			..	X	
Oklahoma	1,100,000	39	X	..	
Texas	1,950,000	50	..	X	
MOUNTAIN					
Montana ‡			..	X	
Idaho ‡			..	X	
Wyoming	70,000	42	..	X	
Colorado	802,500	49	X	..	
New Mexico	62,500	..	X	..	
Arizona ‡			X	..	
Utah	120,000	27	..	X	
Nevada ‡			X	..	
PACIFIC					
Washington	1,330,265	60	X	..	
Oregon ‡			X	..	
California	6,479,979 (g)	63	X	..	
TOTAL ‡			33	15	

Question: IF YOUR CURRENT APPROPRIATION WAS BASED ON A PER PATIENT COST FOR FOOD, WHAT WAS THE FIGURE AND WHAT DOES IT INCLUDE?

STATE	Cost of food per patient per day (cents)	Does the per-patient food-cost figure include: Home Produce? Yes	No	Amount (cents)	Surplus Commodities? Yes	No	Amount (cents)
NEW ENGLAND							
Maine	48.0¢	X	..	-	X	..	-
New Hampshire	51.0	..	X	..	..	X	..
Vermont ‡							
Massachusetts	38.0 (a)	X	..	-	..	X	..
Rhode Island	39.6 (b)	X	..	7.7	..	X	..
Connecticut	33.0 (c)	..	X	..	..	X	..
MIDDLE ATLANTIC							
New York	48.8 (d)	X	..	5.8	..	X	..
New Jersey	38.7 (e)	X	..	10.9	..	X	..
Pennsylvania	43.0	..	X	..	..	X	..
EAST NORTH CENTRAL							
Ohio	51.0	X	..	17.0	..	X	..
Indiana	25.0	..	X	..	..	X	..
Illinois ‡							
Michigan	38.0 (f)	X	..	14.0	..	X	..
Wisconsin ‡							
WEST NORTH CENTRAL							
Minnesota ‡							
Iowa ‡							
Missouri ‡							
North Dakota ‡							
South Dakota	27.9 (g)	..	X	..	..	X	..
Nebraska	50.0	X	..	8.0	..	X	..
Kansas ‡							
SOUTH ATLANTIC							
Delaware	69.5	X	..	25.0	X	..	-
Maryland	45.0 (h)	X	..	(h)	..	X	..
Virginia	35.8	..	X	..	..	X	..
West Virginia ‡	.. (i)						
North Carolina ‡							
South Carolina	46.7	X	..	-	..	X	..
Georgia	45.9	X	..	5.6	X	..	1.6
Florida	62.2 (j)	X	..	8.1	X	..	1.2
EAST SOUTH CENTRAL							
Kentucky	26.0	..	X	..	..	X	..
Tennessee	30.0 (k)	..	X	..	..	X	..
Alabama	35.0	..	X	..	..	X	..
Mississippi	28.6 (l)	..	X	..	..	X	..
WEST SOUTH CENTRAL							
Arkansas	49.7	X	..	16.3	..	X	..
Louisiana ‡							
Oklahoma	40.0	X	..	15.0	..	X	..
Texas ‡							
MOUNTAIN							
Montana ‡							
Idaho ‡							
Wyoming ‡							
Colorado	66.0 (m)	(m)	..	..	(m)	..	..
New Mexico ‡							
Arizona	54.0	X	..	-	..	X	..
Utah ‡							
Nevada ‡							
PACIFIC							
Washington	43.5	X	..	-	..	X	..
Oregon ‡	.. (n)						
California	59.4 (o)	X	..	17.4	X	..	-
TOTAL ‡		19	10		6	23	

‡ No information on this question (19 states).

(a) Massachusetts: Year ending June 30, 1948.

(b) Rhode Island: Year ending June 30, 1948.

(c) Connecticut: "One hospital has a 44¢ cost figure because no herd or poultry is raised."

(d) New York: Year ending March 31, 1948.

(e) New Jersey: Year ending June 30, 1948.

(f) Michigan: "The 1948-49 budget recommends 38¢ on basis of actual usage records from July 1 to December 31, 1947. Costs are running 35¢ to 42 1/2¢ plus 1 to 2¢ for surplus commodities. Cost figure for 1947-48 was 31¢."

(g) South Dakota: "Includes food and clothing. Clothing cost low because of large inventory."

(h) Maryland: "Farm production varies."

(i) West Virginia: Per diem cost figures computed only for total maintenance.

(j) Florida: Net cost per diem per patient for the preparation and serving of food during fiscal year ending June 30, 1947. The total cost was 64.5¢. Proportionate share income from pay patients amounted to 2.3¢.

(k) Tennessee: Not used for budget purposes. We arrived at a flat increase to be distributed by the Hospitals in making up work program.

(l) Mississippi: Includes 4 2/3¢ expense for other items.

(m) Colorado: Includes freight costs for surplus commodities and production costs for home produce.

(n) Oregon: Per diem figures not used for budget purposes.

(o) California: Figure for fiscal year ending June 30, 1949 excluding foodstuffs for employees. Estimate for 1947-48 was 53¢.

Question: HOW DOES THE AMOUNT ALLOWED FOR FOOD IN YOUR CURRENT ALLOWANCE IN YOUR PREVIOUS APPROPRIATION?

STATE	Allowed for in current appropriation	Increase over previous appropriation Amount	Increase over previous appropriation Percent	Appropriation increases were made to cover: higher prices Yes	higher prices No	higher prices Amount	diet improvement Yes	diet improvement No	diet improvement Amount	other factors (specify)
NEW ENGLAND										
Maine	48.0 ¢	7.0 ¢	17%	X	..	7.0 ¢	..	X	..	#
New Hampshire	51.0	15.0	42	X	..	15.0	..	X	..	#
Vermont ‡										
Massachusetts	38.0	8.0	27	X	..	#	..	X	..	#
Rhode Island	39.6	5.3	15	..	X	..	X	..	5.3 ¢	#
Connecticut	33.0	9.-14.0 (a)	..	..	X	(a)	..	X	..	no
MIDDLE ATLANTIC										
New York	48.8	8.7 (b)	22	X	..	5.3	X	..	2.7	0.8¢ - population
New Jersey	38.7	.. (c)	..	..	..	(c)	..	..	(c)	(c)
Pennsylvania	43.0	7.7	22	X	..	7.7	..	X	..	no
EAST NORTH CENTRAL										
Ohio	51.0	10.0 (d)	24	X	..	(d)	X	..	(d)	yes - population
Indiana ‡										
Illinois ‡										
Michigan	38.0	7.0 (e)	22	X	..	7.0	..	..	#	#
Wisconsin ‡										
WEST NORTH CENTRAL										
Minnesota ‡		(f)								
Iowa ‡										
Missouri ‡										
North Dakota ‡		(g)								
South Dakota	27.9	3.5 (h)	14	X	..	(h)	X	..	(h)	(h)
Nebraska	50.0	7.0	16	X	..	5.0	X	..	2.0	#
Kansas ‡										
SOUTH ATLANTIC										
Delaware	69.5	-- (i)		X	..	11.6	X	..	--	#
Maryland	45.0	.. (j)	..	X	..	(j)	X	..	(j)	yes - population
Virginia	35.8	9.5	36	X	..	9.5	..	X	..	no
West Virginia ‡		(k)								
North Carolina ‡		(l)								
South Carolina ‡										
Georgia	45.9	10.9	31	..	..	#	..	..	#	#
Florida	62.2	.. (m)	..	..	..	(m)	..	..	(m)	(m)
EAST SOUTH CENTRAL										
Kentucky ‡										
Tennessee	30.0	6.0 (n)	25	..	..	(n)	..	..	(n)	#
Alabama	35.0	-- (o)	..	..	..	..	..	..	..	..
Mississippi	28.6	8.0 (p)	39	X	..	6.0	X	..	2.0	no
WEST SOUTH CENTRAL										
Arkansas	49.7	11.0 (q)	..	X	..	11.0	..	X	..	no
Louisiana ‡										
Oklahoma	40.0	10.0	33	X	..	10.0	..	X	..	no
Texas ‡										
MOUNTAIN										
Montana ‡										
Idaho ‡										
Wyoming ‡										
Colorado	66.0	10.0	18	X	..	10.0	..	X	..	no
New Mexico ‡										
Arizona ‡										
Utah ‡										
Nevada ‡										
PACIFIC										
Washington	43.5	9.5	28	X	..	8.0	X	..	1.5	#
Oregon ‡										
California	59.4	6.4 (r)	12	..	X	..	X	..	6.52	no

APPROPRIATION COMPARE ON A PER PATIENT BASIS WITH THE

NOTES AND COMMENT

‡ No information on this question (23 states).

No answer to this part of the question.

(a) Connecticut: "An increase in food prices was not allowed above the base month."

(b) New York: "This increase for fiscal year ending March 31, 1948 includes the estimated deficiency."

(c) New Jersey: "We anticipate a deficiency in the food appropriation of $432,000 for fiscal year ending June 30, 1948."

(d) Ohio: "The cost figure is for raw food only. The increase of 10¢ per day covers the increase for prices, diet improvement and population.

(e) Michigan: "The cost figure includes farm produce valued at around 14¢ of the total but it does not include surplus commodities. For the last three fiscal years per diem food costs were as follows: 26.5¢ for 1946-47; 31.0¢ for 1947-48 and 38.0¢ for 1948-49."

(f) Minnesota: "Just recently the Division of Public Institutions has started a per diem food cost study."

(g) North Dakota: "We do not maintain figures on per capita cost of food. Many of the institutions engage in large farming and garden operations and this is used within the institutions with no cost records, although a record is kept of the amount of the different commodities consumed."

(h) South Dakota: "The figure includes food and clothing. We do not have a set amount and therefore can allow increases in food costs necessary."

(i) Delaware: For Delaware State Hospital.

(j) Maryland: "The increase was based on actual expenditures, not appropriation for period of July 1 to September 30, 1946."

(k) West Virginia: "We do not compute per diem food costs—only per diem costs for total maintenance."

(l) North Carolina: "Per diem food costs are computed but the budget is not on this basis. During 1946-47 actual figures for four institutions were 58¢, 64¢, 37¢ and 45¢. The actual for 1947-48 will increase about 25% for goods purchased. Home produce will increase in value likewise but not much in quantity. Same for surplus commodities."

(m) Florida: "Our food costs are based on accounting records. The average per diem costs were 78¢ during the period from July 1, 1947 through November 30, 1947, and if prices continue to advance our food costs may reach an average of 85¢ per patient per day by the end of this fiscal year, June 30, 1948. Our actual food costs for the year ended 6/30/47 were as follows:

Food purchased	$.4427
Donated Surplus Commodities. .	.0123
Produce from our farms and dairy (at cost)	.0810
Direct Labor (kitchens & dining rooms)	.0539
Other (utensils, crockery, supplies, repairs, steam, electricity, water, etc.	.0554
Total - before credits	$.6453
Credits - (proportionate share income from pay patients, etc.)	.0229
Net cost per diem per patient	$.6224

(n) Tennessee: "Computations are made as to various costs per patient but we arrived at a flat increase to be distributed by the institution in making up the work program."

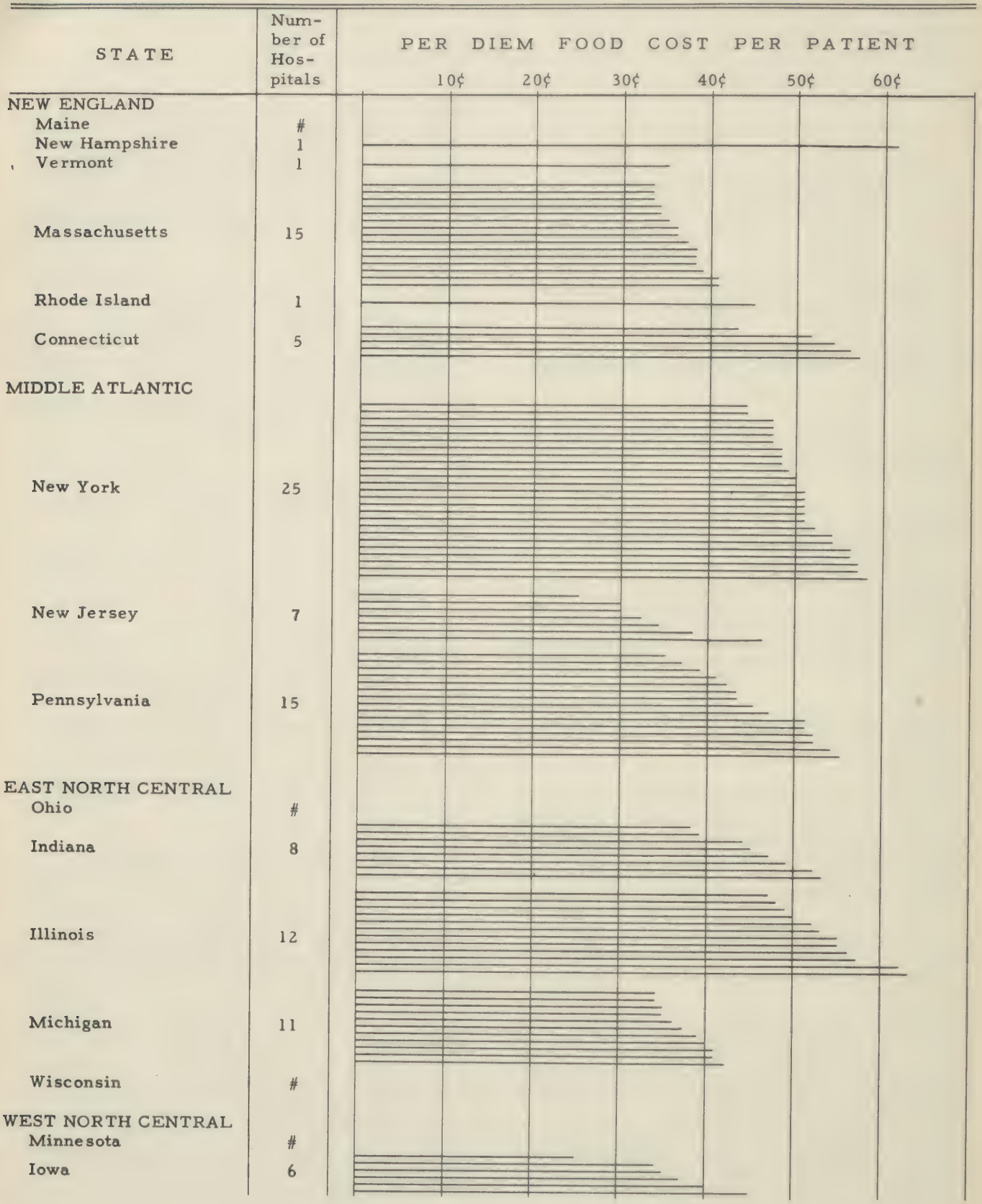
(o) Alabama: Average for the year was based on our cost for the two Alabama hospitals.

(p) Mississippi: This cost figure is for the 1948-50 budget at one of the three Mississippi Hospitals. It includes 4 2/3¢ expense for labor but does not include the value of home produce or surplus commodities.

(q) Arkansas: "Figure is based on actual cost."

(r) California: Cost figure for fiscal year ending June 30, 1949. "The decrease in 'Total' allowed for food compared to the increase allowed for diet improvement results from a change in the distribution of type of patients for which different rations are provided. The cost figure excludes foodstuffs fed or issued to employees."

Question: WHAT WERE THE PER DIEM FOOD COSTS FOR YOUR INDIVIDUAL



HOSPITALS IN THE QUARTER JULY - SEPTEMBER, 1947 ?

STATE	Number of Hospitals	PER DIEM FOOD COST PER PATIENT
		10¢ 20¢ 30¢ 40¢ 50¢ 60¢
Missouri	#	
North Dakota	#	
South Dakota	#	
Nebraska	4	
Kansas	#	
SOUTH ATLANTIC		
Delaware	#	
Maryland	1	
Virginia	6	
West Virginia	#	
North Carolina	#	
South Carolina	1	
Georgia	1	
Florida	2	$0.73 – $1.24
EAST SOUTH CENTRAL		
Kentucky	#	
Tennessee	4	
Alabama	2 *	
Mississippi	#	
WEST SOUTH CENTRAL		
Arkansas	1	
Louisiana	#	
Oklahoma	#	
Texas	5	
MOUNTAIN		
Montana	#	
Idaho	#	
Wyoming	#	
Colorado	4	$0.75 – $0.90
New Mexico	1	
Arizona	1	
Utah	#	
Nevada	1	
PACIFIC		
Washington	5	
Oregon	#	
California	8	
TOTAL	154	

NOTE: # No answer to this question (20 states)
* Average for two hospitals

Contributors to the Survey

Question: NAME OF THE DEPARTMENT, BOARD, OR COMMISSION UNDER WHOSE JURISDICTION YOUR STATE MENTAL HOSPITALS ARE PLACED.

NEW ENGLAND	
Maine	Council for State Institutions
New Hampshire	Board of Trustees for New Hampshire State Hospital
Vermont	Department of Institutions and Corrections
Massachusetts	Department of Mental Health
Rhode Island	Department of Social Welfare
Connecticut	Individual board of trustees for each institution
MIDDLE ATLANTIC	
New York	Department of Mental Hygiene
New Jersey	Department of Institutions and Agencies, State Board of Control
Pennsylvania	Department of Welfare
EAST NORTH CENTRAL	
Ohio	Department of Public Welfare
Indiana	Indiana Council for Mental Health
Illinois	Department of Public Welfare
Michigan	Department of Mental Health
Wisconsin	Department of Public Welfare
WEST NORTH CENTRAL	
Minnesota	Division of Public Institutions, Department of Social Security
Iowa	Board of Control of State Institutions
Missouri	Department of Health and Welfare
North Dakota	Board of Administration, Executive Department
South Dakota	State Board of Charities and Corrections
Nebraska	Board of Control for State Institutions
Kansas	Division of Institutional Management, Board of Social Welfare
SOUTH ATLANTIC	
Delaware	Board of Trustees for State Hospital; Commission for Feebleminded
Maryland	Board of Mental Hygiene
Virginia	Department of Mental Hygiene and Hospitals
West Virginia	West Virginia Board of Control
North Carolina	North Carolina Hospitals Board of Control
South Carolina	Board of Regents for each of the two institutions
Georgia	Department of Public Welfare
Florida	Board of Commissioners of State Institutions
EAST SOUTH CENTRAL	
Kentucky	Department of Welfare
Tennessee	Department of Institutions
Alabama	Board of Trustees for the Alabama Hospitals
Mississippi	Board of Mental Institutions
WEST SOUTH CENTRAL	
Arkansas	Board of Trustees for Arkansas State Hospital
Louisiana	Department of Institutions
Oklahoma	State Mental Health Board
Texas	State Board of Control for State Institutions
MOUNTAIN	
Montana	Board of Commissioners for Insane
Idaho	Charitable Institutions Commission
Wyoming	State Board of Charities and Reform
Colorado	Governor's Office
New Mexico	New Mexico State Hospital, N.M.I.A.
Arizona	Arizona State Hospital Board
Utah	Department of Public Welfare
Nevada	Board of Commissioners for Nevada State Hospital
PACIFIC	
Washington	Department of Public Institutions
Oregon	State Board of Control for State Institutions
California	Department of Mental Hygiene

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Appendix A

. . . . . FORMS FOR STATISTICAL REPORTING

BUREAU OF THE BUDGET
EXECUTIVE OFFICE OF THE PRESIDENT
REVISED MARCH 1945

STATEMENT OF ON-DUTY

(Department
Fiscal

LOCATION	PHYSICIANS						
	Administrative	In-Patient Staff					Out-Patient Staff
		Full Time				Part Time	
		Physicians	Internes	Total	Ratio		
Totals or Averages							

Bureau of the Budget
Executive Office of the President
Revised April 1947

STATEMENT OF ON-DUTY

(Department
Fiscal

LOCATION	ATTENDANTS, ORDERLIES & MAIDS			DIETETIC SERVICE		
	In-Patient		Out-Patient			
	Total	Ratio		Dieticians	Other	Total
Totals or Averages						

IV

Page 1

PERSONNEL ----HOSPITAL

_____
Type of Hospital

_____
or Establishment)
Year _____

DENTAL SERVICE				GRADUATE NURSES							STUDENT NURSES
In-Patient			Out-Patient	Administrative	Teaching	In-Patient				Out-Patient	
						Supervision	General Duty	Total	Ratio		
Dentists	Total	Ratio									

1-315

Page 2

PERSONNEL----HOSPITAL

_____
or Establishment)
Year _____

MEDICAL REHABILITATION						SOCIAL SERVICE WORKERS		MEDICAL TECHNICIANS	
OCCUPATIONAL THERAPY AIDES		PHYSIOTHERAPY AIDES		OTHER MEDICAL REHABILITATION					
Total	Ratio	Total	Ratio	Total	Ratio	Total	Ratio	Total	Ratio

1-244

Bureau of the Budget
Executive Office of the President
Revised April 1947

STATEMENT OF ON-DUTY

(Department
Fiscal

LOCATION	MEDICAL STENOGRAPHIC & CLERICAL			SPECIAL SERVICES		MISCELLANEOUS MEDICAL		
	In-Patient		Out-Patient			IN-Patient		Out-Patient
	Total	Ratio		Total	Ratio	Total	Ratio	
Totals or Averages								

BUREAU OF THE BUDGET
EXECUTIVE OFFICE OF THE PRESIDENT
REVISED MARCH 1945

BED CAPACITY AND

(Department
Fiscal

LOCATION	BEDS AVAILABLE				AVERAGE DAILY PATIENT LOAD			
	General	Neuro-psychi-atric	Tuber-culosis	Total	General	Neuro-psychi-atric	Tuber-culosis	Total
Totals or Averages								

Page 3

PERSONNEL----HOSPITAL

_____
or Establishment)
Year_____

TOTAL MEDICAL PERSONNEL			ADMINISTRATIVE		MAINTENANCE	GRAND TOTAL		
In-Patient		Out-				Full-Time	In-Patient	Out-Patient
Total	Ratio	Patient	Total	Ratio	Total	Total	Ratio	Total

1-244

III

PATIENT LOAD ---- HOSPITAL

_____
Type of Hospital

_____
or Establishment)
Year _____

PER CENT OF UTILIZATION	BASSINETS		PATIENTS DISCHARGED DURING FISCAL YEAR							
			Number Discharged				Average No. In-Patient Days Per Discharge			
	Number	Average Daily Occupancy	General	Neuropsychiatric	Tuberculosis	Total	General	Neuropsychiatric	Tuberculosis	Total

1-315

BUREAU OF THE BUDGET
EXECUTIVE OFFICE OF THE PRESIDENT
REVISED MAY 1943

COST OF
RAW FOOD

_____
(Department
Fiscal

LOCATION	NUMBER OF RATIONS			
	Patients	Employees	Guests	Total
TOTALS OR AVERAGES				

II
HOSPITAL RATIONS
AND SERVICE COSTS

_____
or Establishment)
Year_____

COST OF FOOD CONSUMED						COST OF SERVICE AND HANDLING		TOTAL COST	
PURCHASED FOOD		FARM PRODUCTS		TOTAL FOOD					
Amount	Unit Cost	Amount	Unit Cost	Amount	Unit Cost	Amount	Unit Cost	Amount	Unit Cost

_____ (Signature)

_____ (Title)

1-097

Bureau of the Budget
Executive Office of the President
Revised April 1948

SUMMARY

_____ (Department

ITEM	EXPENSE DISTRIBUTION	A SALARIES	B SUPPLIES AND MATERIALS	C SUBSISTENCE SUPPLIES
1	Administration			
2	Professional Care of Patients			
3	Dietetic Service			(1) (2)
4	Recreational Service			
5	Maintenance & Operation, Bldg. & Grounds		(1) (2)	
6	Laundry Service			
7	Farms			
8	Transportation Service			
9	Total In-Patient — Items 1 to 8			
10	Clothing & Accessories — Indigent Patients			
11	Furniture, Furnishings & Equipment			
12	Total — Items 1 - 11			
13	Maintenance & Operation, Personnel Quarters			
14	Research & Diagnostic Services			
15	Nursing Education			
16	Out-Patient Medical & Dental Services			
17	Capital Expenditures — Land, Buildings, Grounds, & Equipment			
17a	Major Repairs to Structures and Replacement of Fixed Equipment			
18	Care of the Dead			
19	All Other Non-Hospitalization Expenses			
20	Expenses - All Other Institutional Activities and Supply Depots			
	GRAND TOTAL			

Total Hospital Patient Days _____

STORES INVENTORY

	Inventory Beginning Fiscal Year	Acquisitions	Issues
Expendable Supplies			
Subsistence Supplies			
Non-Expendable Supplies			
Total			

1

OF EXPENSES

Type of Hospital

or Establishment)

Fiscal Year____

D FURNITURE FURNISHINGS AND EQUIPMENT	E OTHER EXPENSES	F TOTAL GROSS OPERATING EXPENSE	G CREDITS Q. S. & L. in lieu of Salaries	H OTHER ADJUSTMENTS		I NET OPERATING EXPENSE	J NET COST PER PATIENT DAY
				Debit	Credit		

Inventory End of Fiscal Year	Increase or Decrease	PER PATIENT DAY	
		Stores Issued	End of Year Inventory

(Signature)

(Title)

1-315

REPORT ON PERSONAL SERVICES

NAME OF INSTITUTION	PATIENT DAYS		EXPENDITURE			
					Per patient day	
	This month	Total to date	Amount this month	Total to date	This month	Total to date
1.						
2.						
3.						
4.						
Total						

FOR THE MONTH OF _____

PERSONNEL EMPLOYED														
PHYSICIANS			NURSES			ATTENDANTS			ALL OTHER			GRAND TOTAL		
Budget Quota	Number this month	Percent of quota	Budget Quota	Number this month	Percent of quota	Budget Quota	Number this month	Percent of quota	Budget Quota	Number this month	Percent of quota	Budget Quota	Number this month	Percent of quota

Appendix B

. . . . . COMMENTS ON STATE MENTAL HOSPITAL DIETS

THE ILLINOIS DEPARTMENT OF PUBLIC WELFARE

CASSIUS POUST, Director

1. One state (Indiana) sets up a master menu for a two week period which is used for all mental institutions. This includes a list of quantities for 100 persons, needed to prepare these menus, daily market orders and recipes for many of the items on the menu.

2. Another state (Texas) has a general menu pattern for state institutions to follow. Quantities and types of foods are listed which should be included in each meal so that an adequate diet is served daily.

3. One state (Georgia) sends out a mimeographed master menu for seven days and this is apparently used over a period of several months.

4. Ten states show basic food allowance tables which list per capita food requirements to provide an adequate diet for patients. These were set up in various ways, either for a quarter or for one day, but there was considerable similarity in amounts listed. A minimun serving of four ounces of meat per patient per day was shown. The minimum daily serving of milk was 7 ounces, with 24 ounces per day as the maximum.

5. In almost all of the menus a low cost diet was used for patients, while employees received either a moderate or high cost menu.

6. In three states extra food was listed on the menu for working details of patients. This was usually only one item, such as meat, eggs, fruit or potatoes. One institution listed daily lunches sent to field workers. Nourishments were listed on two sets of menus, but not in detail.

7. A special menu for infirmary patients was written in three states. This included more easily digested foods and extra protein foods. One of the general menus included soup each day for senile patients.

8. It is often necessary to serve a special item requiring more preparation to only half the patients at one time. In one state, pancakes were served to men patients one morning and women patients the next, while in another state roast meats and ice cream were served to only half of the patients at a time.

9. Two states wrote special menus for tuberculosis patients, and one institution listed special items on the general menu for these patients.

THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ROLAND R. CROSS, M. D., Director

Diet schedules indicating the menu plan for State Mental Hospitals were received from 18 states. The material received consisted of the per capita food requirement on a quarterly or daily basis, sample menus for one week or more or both, the basic ration chart and menus. In each case, the nutritional adequacy was analyzed and the results tabulated. See table on opposite page. Such an analysis was difficult due to the fact that portion sizes are not indicated on the menus. Standard portions were used and minimum amounts of fat were included so that the total calories charted may be low.

Basic Rations indicating the per capita food requirement were received from 9 states. It was impossible to complete the calculations in three instances due to the fact that the amount of money allowed for fruit was indicated rather than the pounds or ounces allowed. The analysis shows that the six basic rations calculated were nutritionally adequate in all respects with the exception of calcium in two instances. In these two cases it is entirely possible that there was a misinterpretation of the material submitted.

Sample menus from 12 states were evaluated. The results are indicated on the table and are summarized as follows:

	Adequate	Questionable	Low
Calories	2	3	7
Protein	10	0	2
Calcium	11	0	1
Iron	9	1	2
Vitamin A	4	1	7
Ascorbic Acid	4	2	6
Thiamine	5	2	5
Riboflavin	11	0	1
Niacin	1	3	8

Since the sample menu may not give a true picture of the situation, all menus submitted were checked for the basic daily requirements with the following results:

Arkansas: The small amount of meat allowed in all menus accounts for the deficiency in thiamin and niacin indicated on the chart. The absence of raw vegetables and citrus fruits accounts for the inadequate supply of ascorbic acid and affects the Vitamin A content of the diet. No eggs were listed except for outside workers. No butter, oleo or other fats were indicated.

NUTRITIONAL ANALYSIS OF STATE MENTAL HOSPITAL DIETS

STATE	Calories	Protein (gm.)	Fat (gm.)	Carbohydrate (gm.)	Calcium (gm.)	Phosphorous (gm.)	Iron (mg.)	Vitamin A (I.U.)	Ascorbic Acid (mg.)	Thiamine (mg.)	Riboflavin (mg.)	Niacin (mg.)
NRC Requirements	2100 -2500	60 -70			0.8		12	5000	70 -75	1.1 -1.2	1.5 -1.6	11 -12
ILLINOIS												
Basic Ration	2,773	93.6	99	374	1.35	1.66	17.9	9,097	127	1.29	2.26	11.6
Daily Menu	--	--	--	--	--	--	--	--	--	--	--	--
ARKANSAS												
Daily Menu	1,856	69.2	67.6		1.18	1.16	11.4	2,980		.86	1.97	6.4
Daily Menu *	2,296	106.2	100.6	245	1.19	1.35	14.7	3,005	35	.96	2.13	9.5
CONNECTICUT												
Basic Ration	--	--	--	--	--	--	--	--	--	--	--	--
Daily Menu	1,635	66.5	78.0	169	1.11	1.25	11.1	10,040	88	.79	1.95	8.7
MISSISSIPPI												
Daily Menu †	1,537	48.2	64.0	194	.92	1.01	5.6	9,260	55	.63	1.62	3.6
Daily Menu §	1,495	43.6	59.9	216	.79	.88	5.1	2,383	68	.69	1.42	4.3
GEORGIA												
Basic Ration	2,379	107.1	76.2	315	.52 or 1.02	1.36	24.2	14,362	74 or 120	1.14	1.77	21.0
Daily Menu	1,140	45.1	46.2	135	.17	.57	7.4	1,730	19	.54	.53	7.9
WASHINGTON												
Basic Ration	--	--	--	--	--	--	--	--	--	--	--	--
Daily Menu ¶	2,426	75.6	122.0	303	1.55	1.61	10.2	5,630	114	1.23	2.51	8.7
SOUTH DAKOTA												
Basic Ration	1,615	71.5	59	202	1.20	1.37	11.1	2,820	60	.95	1.99	8.5
Daily Menu *	2,010	93.5	76	241	1.23	1.63	15.2	3,030	68	1.16	2.20	13.6
NEW JERSEY												
Basic Ration	3,035	99.5	215	314	.90-1.15	1.76	24.7	15,195	93-116	1.30-1.34	2.51	15.5
Daily Menu	2,150	82.9	82	272	.90	1.43	17.8	18,905	50	1.14	2.82	17.9
NEW MEXICO												
Basic Ration	--	--	---	--	--	--	--	--	--	--	--	--
Daily Menu	1,811	75.6	71	220	1.29	1.42	8.6	3,120	27	.79	2.07	8.0
MINNESOTA												
Basic Ration	--	--	--	--	--	--	--	--	--	--	--	--
Daily Menu	1,625	66.0	54	212	1.06	1.22	10.1	3,165	47	.89	1.92	8.7
MARYLAND												
Basic Ration	--	--	--	--	--	--	--	--	--	--	--	--
Daily Menu	2,006	79.2	80	200	1.21	1.48	11.4	3,450	25	1.04	2.16	9.5
INDIANA												
Basic Ration	--	--	--	--	--	--	--	--	--	--	--	--
Daily Menu	1,771	71.2	74	226	.88	1.19	11.8	2,951	108	.83	1.56	8.8
PENNSYLVANIA												
Basic Ration	2,884	121.7	93	399	1.20	1.87	20.6	10,101	91-114	1.25-1.29	2.45	16.0
Daily Menu	--	--	--	--	--	--	--	--	--	--	--	--
TEXAS												
Basic Ration	2,696	106.9	91	361	1.36	1.80	21.1	13,254	98	1.19	2.52	15.3
Daily Menu	2,037	74.7	88	238	1.09	1.35	11.6	9,080	72	1.03	1.98	9.8
CALIFORNIA												
Basic Ration	2,484	88.4	69	374	.63	1.26	21.7	14,941	123	1.01	1.49	15.0
Daily Menu	--	--	--	--	--	--	--	--	--	--	--	--

Massachusetts, New York, and Rhode Island not included because rationed amounts of some items were not given.

* for workers; † for white; § for colored; ¶ for boys and girls.

California: No menus submitted.

Connecticut: These menus are most probably adequate although the sample menu indicates insufficient calories, thiamine and niacin. It was impossible to tell the exact amount of milk and fats allowed and whether or not whole grain cereals or enriched cereal products are included daily. Also, eggs were included only twice in one week.

Georgia: These menus are inadequate in all respects although the basic ration chart is adequate. No milk, raw vegetables, citrus fruit, whole grain or enriched cereal, butter or oleomargarine are listed. Eggs are included only once in one week.

Illinois: No menus submitted. Basic ration chart adequate.

Indiana: Here again, the calories charted are probably lower than actually as the amount of butter and other fats included is not indicated on the menus. The amount of milk included may also be more than the amount charted. This would affect the totals in respect to Vitamin A, thiamine and niacin.

Maryland: No raw vegetables are indicated on these menus. Citrus fruit is served twice a week. This accounts for the insufficiency of ascorbic acid and probably Vitamin A and niacin.

Massachusetts: No menus submitted.

Minnesota: No raw vegetables are included in these menus. No citrus fruits and no eggs served as such. The sample menu shows an insufficient amount of Vitamin A, ascorbic acid, thiamine and niacin.

Mississippi: Only two days' menus were submitted so that they may not be indicative of all menus. These menus are deficient nutritionally. Meat is not included daily, raw vegetables are not always included and no citrus fruit is indicated. More information is needed for a true analysis.

New Jersey: In the sample menu the Vitamin A is high because liver loaf is on this menu and the ascorbic acid is somewhat low because no citrus fruit, tomatoes or other food having an appreciable amount of ascorbic acid is included. The majority of these menus are most probably nutritionally adequate.

New Mexico: The sample menu is nutritionally inadequate but the remainder of the menus appear to be somewhat better. Citrus fruit is included only twice in one week, no eggs are indicated and no butter or oleomargarine listed. Therefore, the adequacy of all menus is questionable.

New York: No menus submitted.

Pennsylvania: No menus submitted.

Rhode Island: No menus submitted.

South Dakota: In these menus no raw vegetables, no citrus fruits and no eggs (with the exception of those used in cooking) are included. The sample menu is low in Vitamin A, ascorbic acid and niacin. This is apparently typical. The calories are most probably higher than charted.

Texas: Niacin is somewhat low in the sample menu. This may not be typical. The ascorbic acid is questionable because no citrus fruit is indicated. The sweet potatoes in the sample menu accounts for the adequate amount charted.

Washington: In the sample menu niacin is somewhat low but in general these menus are apparently adequate in all respects.

THE UNIVERSITY OF ILLINOIS

DEPARTMENT OF HOME ECONOMICS

E. EVELYN SMITH, Associate Professor of Institution Management

A study of the menus submitted shows wide variation in type, adequacy and equality of meals being served in tax-supported institutions throughout the country. It would indicate the need for a more uniform method of determining the budget or for a wiser use of money now appropriated. A plan for determining the per capita cost of a minimum adequate dietary based upon the standards as set up by the National Research Council would seem to be a good one, providing activity, age, season and general marketing conditions are considered in determining this per capita cost.

Any tax-supported institution exists for the patients or inmates, and the staff and employees or resident group are there to care for them. It is obvious, then, that any method of computing budget should insure at least an adequate minimum diet for this main group. If it is necessary to increase the quality or quantity of the menus served to the staffs, it should not be done at the expense of the patient's or inmate's diet.

The best method of accomplishing this is to serve "patient-or inmate-centered menus", or a menu, which with minor adjustment mainly in quantity, will meet the nutritive requirement of all groups in the institution and which can easily be costed on a per capita basis.

If, for any reason, this same menu cannot be served to all groups, a menu pattern for each group should be set up and the amount over the minimum

basic allowance determined and the per capita cost be established in the budget.

Either of these methods, if checked often, would seem to give a true picture of what is actually being served to each group. It would avoid what was found in one of the menu studies, when the patients had no eggs and almost no meat during the week, while the staff had eggs five times a week and meat twice daily.

A minimum adequate dietary is one that is needed by all human beings, no matter what their status, and all budgets should insure the serving of it to all groups in every institution. If allowances can be increased for certain resident groups, the budget should be made accordingly.

Insofar as the budget plan of basing costs on specific daily rations insures a reasonable costing of an adequate diet to patients, inmates, and the resident group, it would seem to be a good plan and should produce more uniform results.

IOWA STATE COLLEGE

HOME ECONOMICS DIVISION

MARJORIE M. McKINLEY, Assistant Professor of Institution Management

After reviewing the California and Rhode Island reports on food requirements and cost of rations the following observations and suggestions seem pertinent. The reviewer is not intimately familiar with the problem of food budgeting in state mental hospitals. The opinion expressed here is based on readings in that field and on experience in other types of food service.

1. When food costs are estimated on the basis of a daily ration, difference in the nutritional needs of the different groups served should be recognized and rations established for the different groups which will provide an adequate diet for each group.

2. It would be desirable if the groups needing different rations could be standardized. To establish standardized divisions of groups served would require the consideration of many institutions. In the reports from two states those served were grouped differently:

California	Rhode Island
General Patients	Adults
Hospital T.B.	Active Men
Working Patients	Aged Men
Feebleminded	Children 1 to 12
Employees	Children 12 to 16
	Boys 12 to 16
	Employees

Certainly, the cost of employees' meals should be separated from patients' meals. Would it not be advisable, if possible, to further subdivide the ration for employees into "staff" and "other employees."

3. As has been done in the California report, it would seem advisable to show the current price. The addition of a column for unit of purchase adjacent to the unit price may be desirable.

4. As has been done in the California report, listing the quantity of the ration as well as the price would seem desirable. This comparison would make for ease of determining whether a revision of the estimated cost was due to a fluctuation in price or a change in the basic ration.

5. Certainly it is desirable to distribute the estimated food costs according to food groups, and it is to be preferred if this grouping can be given in some detail as is given in the California report. Some breakdown of the meat group is probably desirable. In institutions it would seem advisable to have leafy green and yellow vegetables as a separate group. Somewhat different food groups than are given in either the Rhode Island or California reports are sometimes used. See examples in reference 7.

6. The diet materials received from the states evidence a recognition of the need to standardize procedures and records in state institutions. It is not practical, of course, to compare food cost figures if methods of accounting are not standardized. Two questions which arise in this connection are:

a. How are the food commodities produced on the institution's farm priced? In establishing the price is any consideration given to quality of the food?

b. How are government commodities received by the institution recorded?

A record of operations should be maintained which makes it possible to compare the actual quarterly rations and amounts spent, classified according to groups served and food groups, with the estimated ration and cost. Maintenance of such records is dependent on providing adequate clerical assistance for the person in charge of the food service.

7. A suggested addition to the California report would be a breakdown of the total to show the estimated cost per person per day.

8. Although the amount purchased of the different food groups is some indication of the

adequacy of diets, it is always important to re-emphasize that the adequacy of one's diet is dependent on the food he consumed rather than the food that was purchased for him to consume. That is to say, losses due to preparation waste, overcooking, holding of food for long periods, and plate waste must all be considered. Only by efficient management of the food service department can such losses be minimized. If the food served is not well prepared and attractively served it may often be rejected.

9. It would seem advisable, as has been done in the California report, to estimate cost of rations on a quarterly, rather than a yearly basis.

LIST OF REFERENCES

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3. Eck, E. M. A Food Cost Control System in A Dietary Department. Jr. American Dietetic Assoc. 19:98-100. February, 1943.

4. Gruber, T. K. and Hammond, C. A. Food Waste As An Administrative Problem. American Jr. Psychiatry. 99:886. May, 1943.

5. Louser, K. E. The Food Production Program in the State Institution. Jr. American Dietetic Assoc. 20:240-242. April, 1944.

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9. Tallman, F. F. Food and the Mentally Ill. Jr. American Dietetic Assoc. 23:6-7. January, 1947.

Appendix C

. . . . . THE QUESTIONNAIRE

QUESTIONNAIRE: COMMODITY COSTS AND BUDGETING FOR MENTAL HOSPITALS

State of _____

1. Name of Department, Board, or Commission under whose jurisdiction the mental hospitals are placed.

_____

2. How does your state handle budgets and appropriations for state mental hospitals?

	BUDGET	APPROPRIATION
For each hospital separately	( )	( )
For hospitals as a group	( )	( )
No specific allocation to hospitals	( )	( )

3. Your state appropriations are made

Biennially ( )
Every year ( )

4. In the State of Illinois current biennial appropriations run from July 1, 1947, to June 30, 1949.

In your state, current appropriations run from _____, 194_, to _____, 194_.

5. How do you compute figures on per capita costs for maintenance for mental hospitals in your state?
(Note: maintenance includes all expenditures for operation)

Do you follow the Department of Commerce classification? Yes ( ) No ( )

Do your figures include all items of current operating expense? Yes ( ) No ( )

Do your figures include permanent improvements? Yes ( ) No ( )

Do your figures include purchases of equipment? Yes ( ) No ( )

Which of the items below are included in your calculation of per capita costs for maintenance? Please check:

Personal Services (salaries & wages)	( )	Communication	( )
Food	( )	Repairs (labor)	( )
Clothing and Clothing Material	( )	Reparis (material)	( )
Household, Laundry, etc.	( )	Repairs (building)	( )
Medical, Surgical, Laboratory, etc.	( )	Equipment-Replacements	( )
Farm and Garden Expense	( )	Equipment-Additional	( )
Fuel, Light, Power, and Water	( )	Special Repairs	
Traveling Expense	( )	Others (Specify):	
Automotive Expense	( )	_____	
Printing and Advertising	( )	_____	
Rentals	( )	_____	

With further reference to your per capita cost for maintenance figure, do you divide the total cost by the average daily patient population? Yes ( ) No ( )

If not, how do you determine it? _____

_____

NOTE: Please enter your actual per capita cost for maintenance figures on Table I which is attached at the end of this questionnaire.

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Page 2

6. Some states do not consider as operating expense those expenditures in behalf of the patients made from special funds on expense borne by other agencies. We would like to know the practice in your state.

	Paid by local governments and counties	Paid by patients or their guardians or their relatives
Are your institutions reimbursed?	Yes ( ) No ( )	Yes ( ) No ( )
Is contribution from the above included in calculating your per capita costs?	Yes ( ) No ( )	Yes ( ) No ( )
Do your per capita costs figures include the entire cost of medical care?	Yes ( ) No ( )	Yes ( ) No ( )
the entire cost of clothing patients?	Yes ( ) No ( )	Yes ( ) No ( )
the entire cost of boarding out patients?	Yes ( ) No ( )	Yes ( ) No ( )

7. What do your average daily population figures exclude?
Do your average daily population figures exclude

Patients in convalescent care in the institution?	Yes ( ) No ( )
Patients in convalescent care outside the institution?	Yes ( ) No ( )
Out patients?	Yes ( ) No ( )
Others (Specify): _____	

8. How are commodities for your mental hospitals purchased? (See footnote)

Central State Purchasing Agent	( )
Department Purchasing Agent	( )
Each Individual Institution	( )
Both Purchasing Agent and Institution	( )
Others (Specify): _____	

9. In preparing the Illinois 1947-49 biennial budget for the mental hospitals, estimates of commodity costs were projected from the quarter, October through December 1946, as the base period. Did you estimate commodity costs on the basis of:

A particular month	( ) If so, base period was _____
A particular quarter	( ) If so, base period was _____
A particular year	( ) If so, base period was _____

10. For budget purposes, do you estimate commodity prices on the basis of:

Retail price level	( )
Wholesale price level	( )
Somewhere between the retail & wholesale price levels	( )
Your own price level as shown by your own state purchasing department	( )
Cost accounting methods	( )
Others (Specify): _____	

NOTE: In this questionnaire the word commodities is used to mean "expenditures in connection with current operation and maintenance for the purchase of articles of a consumable nature which show a material change or appreciable depreciation with first usage."

11. For budget purposes, do you use price indexes to estimate commodity prices?

Bureau of Labor Statistics ( )
Your own ( )
Others (Specify): _____

12. Do you price suplus commodities donated by the federal government and the farm products produced on the institutional farms? If so, how do you price them?

	PRODUCTS OF INSTITUTIONAL FARMS	SURPLUS COMMODITIES
Retail price level		( )
Wholesale price level	( )	( )
Somewhere between the retail and wholesale price levels	( )	
Your own price level as shown by your own state purchasing department		( )
Cost accounting methods	( )	( )
Others (Specify): _____	( )	

13. What is your total current appropriation for commodities for all your mental hospitals? (See footnote)

TOTAL FOR COMMODITIES FOR____ FISCAL YEARS IS $_____

How much of this do you estimate is for food? $_____

14. Is your current appropriation for commodities (as stated in Ouestion 13) to all your mental hospitals an increase over your last appropriation for commodities? Yes ( ) No ( )

THIS TOTAL INCREASE ALLOWED FOR ALL COMMODITIES WAS $_____

Did you allow an increase for prices?____ If so, how much? $_____
How much of your increase was allowed for food? $_____
Did you allow any increase for diet improvement?____ If so, how much? $_____
Did you allow an increase for any other reason?
If so, specify what _____, and how much $_____
_____, and how much $_____

NOTE: In this questionnaire the word commodities is used to mean " expenditures in connection with current operation and maintenance for the purchase of articles of a consumable nature which show a material change or appreciable depreciation with first usage."

COMMENTS:

Page 4

15. Do you compute per diem food costs per patient? Yes ( ) No ( )

If you budget on the basis of a per diem per patient cost figure for food, what was the figure for your current appropriation?

TOTAL PER DIEM PER PATIENT COST OF FOOD FOR ALL MENTAL HOSPITALS WAS ____¢

Did this figure include Surplus Commodities? ____ if so, how much ____¢

Did this figure include Home Produce from institutional farms _____ if so, how much ____¢

Did this figure include other items such as labor, etc. Please specify.

_____ if so, how much ____¢

_____ if so, how much ____¢

16. Did this per diem per patient cost figure on food (as stated in Question 15) allow for an increase over the per diem per patient cost figure used in your last appropriation? Yes ( ) No ( )

THE TOTAL INCREASE ALLOWED FOR FOOD WAS _____¢

Did you allow an increase for diet improvement? ____ if so, how much ____¢

Did you allow an increase for food prices? ____ if so, how much _____¢

Did you allow an increase for any other reason? _____ please specify:

_____ if so, how much ____¢

_____ if so, how much ____¢

17. Do you base your food costs on a diet schedule?

Your own ( )
U. S. Department of Agriculture Schedule for low priced meals ( )
Others (Specify):

_____

_____

18. Enclosed is a copy of diet schedules used for mental institutions in the State of Illinois. These schedules are furnished through the courtesy of the Supervisor of Division of Home Economics and Nutrition, Department of Public Welfare. She will be glad to answer any questions you may have concerning diet schedules in Illinois. Won't you send us copies of your diet schedules and some sample menus? What do you consider an adequate diet?

COMMENTS:

19. Please fill in the tables attached at the end of this questionnaire. Your comments on the commodity cost and budgeting problem for mental hospitals will also be of great interest and assistance to us.

Questionnaire Signed By _____

Title _____

Return completed questionnaire
to
T. R. Leth, Budget Director
and Assistant to the Director of Finance
Department of Finance, State of Illinois
Springfield, Illinois
(addressed envelope enclosed)

COMMENTS:

TABLE I

PER CAPITA COSTS FOR MAINTENANCE
STATE OF _____

	Name of Institutions (Mentally Ill and Mentally Deficient)	Average Daily Inmate Population	Per Capita Costs for Maintenance Fiscal Year from _____, 194_ to _____, 194_
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

COMMENTS:

TABLE 2

CURRENT PER DIEM FOOD COSTS PER PATIENT
STATE OF _____

Name of Institutions (Mentally Ill and Mentally Deficient)	Per Diem Food Costs Per Patient Quarter (July-September) 1947	Per Diem Food Costs Per Patient September 1947
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

COMMENTS:

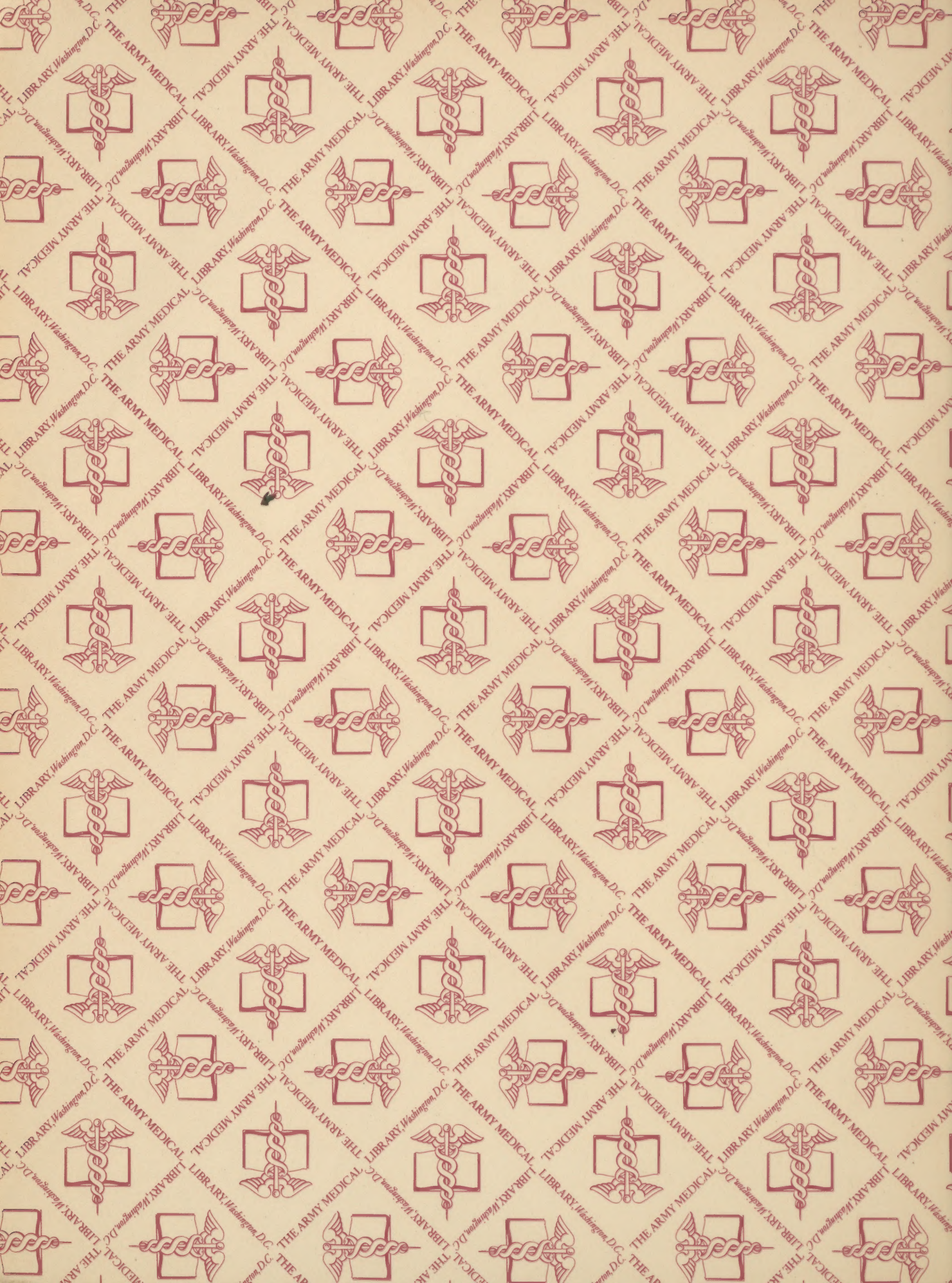
TABLE 3

PRICES PAID FOR PURCHASED FOOD AT MENTAL HOSPITALS
IN STATE OF _____

Here is a list of foods which we consider important to food costs in Illinois. Please indicate the prices you are paying for these essential foods. (Note that the prices requested are on Purchased Food only)

	Unit	Average Price (July-Sept. 1947)	Average Price (September 1947)
Dairy Products			
Butter			
Butterine (Oleomargarine)			
Cottage Cheese			
Milk, whole			
Eggs			
Fruits and Vegetables			
Oranges			
Lettuce			
Peaches, dried			
Prunes, dried			
Navy Beans			
Meat			
Total Beef (all varieties)			
Certain cuts of beef important in your institutional diets (specify)			
Frankfurters			
Ham			
Pork Sausage			
Miscellaneous			
Coffee			
Flour			
Macaroni			
Rolled Oats			
Soda Crackers			
Sugar			

COMMENTS: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